



**Office of the District  
Medical Examiner**

**DISTRICT ONE**

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## Final Disposition Waiver

I, \_\_\_\_\_, hereby waive my right of final disposition,  
(Legally Authorized Person)

of \_\_\_\_\_, to \_\_\_\_\_.  
(Decedent's Name) (Appointed Name)

I understand by waiving my rights I hereby release the Medical Examiner, Gulf Coast Autopsy Physicians, PA., and its officers, directors, employees and agents, and \_\_\_\_\_ County, from any and all claims, losses, or damages which the undersigned or any of the heirs, beneficiaries, representatives or successors of the Decedent may have against or be entitled to recover as a result of waiving my final disposition rights.

Signed this \_\_\_\_\_ Day of \_\_\_\_\_, 2007

\_\_\_\_\_  
(Signature of Legally Authorized Person)

Witnessed this \_\_\_\_\_ Day of \_\_\_\_\_, 2007

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Telephone Number)