Spokane County
WASHINGTON

OFFICE OF THE MEDICAL EXAMINER

MEDICAL EXAMINER
SALLY S. AIKEN, MD
FORENSIC PATHOLOGIST

MEDICAL EXAMINER
JOHN D. HOWARD, MD
FORENSIC PATHOLOGIST

Authorization for Release of Specimens held by the Spokane County Medical Examiner's Office for the Purpose of DNA / Paternity Testing

Date: _____

I, _____ am the _____
(RELATIONSHIP TO DECEDENT)

To: _____ **Date of Death:**_____
(DECEASED'S NAME)

Date of Birth:_____ _____
(SUBPOENA NUMBER / COURT ORDER NUMBER)

I AUTHORIZE THE SPOKANE COUNTY MEDICAL EXAMINER TO RELEASE THE REQUESTED SPECIMENS, ON MY BEHALF, TO:

_____
(NAME/COMPANY/FIRM)

_____ _____
(ADDRESS) (ADDRESS)

_____ _____
(CITY/STATE/ZIP) (PHONE)

I UNDERSTAND THAT THE SPOKANE COUNTY MEDICAL EXAMINER'S OFFICE IS NOT REPONSIBLE FOR THE LABORATORY SELECTION, TEST SELECTION, TEST PERFORMANCE, OR INTERPRETATION OF THE RESULTS OF THE DNA / PATERNITY TESTING. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL SHIPPING AND LAB TESTING FEES IN ADDITION TO THE $ 100.00 NON-REFUNDABLE FEE PAID TO THE SPOKANE COUNTY MEDICAL EXAMINER FOR PROCESSING, STORAGE, RETRIEVAL, AND HANDLING OF BIOLOGICAL SPECIMENS. THE $100.00 FEE IS ENCLOSED

_____ _____
(PRINT NAME OF AUTHORIZING FAMILY MEMBER) (SIGNATURE OF AUTHORIZING FAMILY MEMBER)

_____
(DATE)