Arizona Bureau of Vital Records

Human Remains Release Form (HRRF)

Hospitals, nursing care institutions, and hospice inpatient facilities are required to complete the HRRF. The Vital Records Statutes and Administrative Rules governing the HRRF are: Arizona Revised Statutes (A.R.S.) §36-326(B), (C) and Arizona Administrative Code R9-19-301. The HRRF form must also be completed in compliance with A.R.S. §§11-593(A), 36-664 and 36-843.

☐ **DEATH**	☐ **FETAL DEATH**
A death occurs when a person is born alive and then dies at some point after birth (e.g., minutes, days, years).	Pursuant to A.R.S. 36-301(14), a fetal death means the cessation of life before the complete expulsion or extraction of an unborn child from the child's mother that is evidenced by the absence of breathing, heartbeat, umbilical cord pulsation or definite voluntary muscle movement after expulsion or extraction. Further defined in A.R.S. 36-329 as "... a fetal death occurring in this state after a gestational period of twenty completed weeks or if the product of human conception weighs more than 350 grams."

DECEASED PERSON'S INFORMATION

1. FACILITY NAME AND STREET ADDRESS, CITY/TOWN, COUNTY

2. DECEASED PERSON OR FETUS FULL NAME (FIRST, MIDDLE, LAST)	3. DATE OF BIRTH (MM/DD/YYYY)	4. SOCIAL SECURITY# OR MRN #

5. SEX ☐ Female ☐ Male	6. DATE OF DEATH (MM/DD/YYYY)	7. TIME OF DEATH/DELIVERY (HH:MM) ☐AM ☐PM ☐Military

FETAL DEATH INFORMATION (IF APPLICABLE)

8. MOTHER'S NAME (FIRST, MIDDLE, LAST)	9. MOTHER'S MAIDEN LAST NAME	10. DATE OF DELIVERY (MM/DD/YYYY)	11. ESTIMATED GESTATIONAL AGE (IF UNKNOWN, PROVIDE WEIGHT) ☐Weeks ☐Grams

PERSON AUTHORIZING THE FACILITY TO RELEASE THE HUMAN REMAINS (Deceased Person's Representative)

12. FULL NAME (FIRST, MIDDLE, LAST)	13. PHONE # (XXX) XXX-XXXX	14. RELATIONSHIP TO DECEASED

CURRENT CARE HEALTH CARE PROVIDER (i.e. MD, DO, PA, NP, ND) EXPECTED TO SIGN MEDICAL CERTIFICATION OF DEATH

15. FULL NAME (FIRST, MIDDLE, LAST)	16. PHONE # (XXX) XXX-XXXX	17. FAX # (XXX) XXX-XXXX	18. EMAIL ADDRESS (XXXXXX@XX.COM)

MEDICAL INFORMATION FOR DECEASED PERSON

19. THE MOST RECENT DIAGNOSIS IN THE PERSON'S MEDICAL RECORD IS:

20. INDICATE WHETHER THE DECEASED PERSON HAD BEEN DIAGNOSED WITH OR WAS SUSPECTED OF HAVING ANY OF THE FOLLOWING, AS STATED IN THE MEDICAL RECORD AT THE TIME OF DEATH (CHECK ALL THAT APPLY)

☐ Infectious Tuberculosis	☐ Hepatitis C	☐ Human Immunodeficiency Virus	☐ Other _____
☐ Hepatitis B	☐ Rabies	☐ Creutzfeldt-Jakob Disease	☐ **NONE OF THE ABOVE APPLY**

21. NOTIFICATION PER ARS 11-593 REQUESTED UNDER THE FOLLOWING CIRCUMSTANCES

• Death resulting from violence.	• Death when not under the current care of a health care provider as defined pursuant to section 36-301.
• Unexpected or unexplained death.	
• Death of a person in a custodial agency as defined in section 13-4401.	• Death occurring in a suspicious, unusual or non-natural manner, including death from an accident believed to be related to the deceased person's occupation or employment.
• Unexpected or unexplained death of an infant or child.	
• Death occurring as a result of anesthetic or surgical procedures.	• Death suspected to be caused by a previously unreported or undiagnosed disease that constitutes a threat to public safety.
• Death involving unidentifiable bodies.	

22. WAS THE DEATH REPORTED? ☐YES, SPOKE TO _____ ☐NO ☐N/A

23. **HOSPITAL USE ONLY:** If the deceased individual's human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 36, Chapter 7, Article 3, and the person authorized in A.R.S. §36-843 has not made or refused to make an anatomical gift, indicate whether the organ procurement organization has been notified that the deceased individual's human remains are being removed from the hospital. ☐ YES ☐ NO

PERSON REPRESENTING THE FACILITY THAT RELEASED THE HUMAN REMAINS

24. FULL NAME (PRINT)	25. SIGNATURE	26. DATE & TIME (MM/DD/YYYY)(HH:MM) ☐AM ☐PM ☐Military

PERSON ACCEPTING CUSTODY OF THE HUMAN REMAINS

27. FULL NAME (PRINT)	28. SIGNATURE	29. DATE & TIME (MM/DD/YYYY)(HH:MM) ☐AM ☐PM ☐Military

BUSINESS NAME OF ESTABLISHMENT ACCEPTING CUSTODY OF HUMAN REMAINS (i.e. FUNERAL HOME, ME, DONATION FACILITY)

30. BUSINESS NAME (PRINT)

31. HOSPITAL STICKER

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Completion Guidance

The following table provides guidelines for completing the fields on the HRRF when there is a fetal death or a death. The "X" in the column indicates if the field should be completed based on the vital event.

Field #	Field Name	Field Description	Fetal Death	Death
	DEATH	Check the appropriate box for the type of event. A death occurs when a person is born alive and then dies at some point after birth (e.g., minutes, days, years).		X
	FETAL DEATH	Check the appropriate box for the type of event. Pursuant to A.R.S. 361 301(14), a fetal death means the cessation of life before the complete expulsion or extraction of an unborn child from the child's mother that is evidenced by the absence of breathing, heartbeat, umbilical cord pulsation or definite voluntary muscle movement after expulsion or extraction. Further defined in A.R.S. 361 329 as "... a fetal death occurring in this state after a gestational period of twenty completed weeks or if the product of human conception weighs more than 350 grams."	X	
DECEASED PERSON'S INFORMATION				
1	FACILITY NAME AND STREET ADDRESS, CITY/TOWN, COUNTY	Facility where decedent died. Please list complete facility name. Abbreviations are not acceptable. List the address, city/town where the facility is located.	X	X
2	DECEASED PERSON OR FETUS FULL NAME	Print the decedent's current legal name: first, middle, last and suffix (if applicable).	X	X
3	DATE OF BIRTH	Print the decedent's date of birth in the numerical format of MM/DD/YYYY.		X
4	SOCIAL SECURITY# OR MRN #	Print the decedent's U.S. social security number or the facility medical record number.		X
5	SEX	Select the applicable check box for the sex of the decedent (i.e. male, female).	X	X
6	DATE OF DEATH	Date the decedent died. List in the format of MM/DD/YYYY.		X
7	TIME OF DEATH/ DELIVERY	Time the decedent died. Print the time of death in numerical format and list one of the following time indicators: AM, PM (12-hour clock) or Military (24-hour clock). List the format of HH:MM.	X	X
FETAL DEATH INFORMATION (IF APPLICABLE)				
8	MOTHER'S NAME	Print the mother's current legal name: first, middle and last name.	X	
9	MOTHER'S MAIDEN LAST NAME	Print the last name of the decedent's mother prior to her first marriage.	X	
10	DATE OF DELIVERY	Date the decedent was extracted from its mother. List the date of delivery in the numerical format of MM/DD/YYYY.	X	
11	ESTIMATED GESTATIONAL AGE	Print the gestational age of the decedent. Gestational age is a term used to describe how far along the pregnancy was. It is measured in weeks, from the first day of the woman's last menstrual cycle to the date of delivery. If the gestational age is unknown, please list the decedent's weight in grams.	X	

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Field #	Field Name	Field Description	Fetal Death	Death
PERSON AUTHORIZING THE FACILITY TO RELEASE THE HUMAN REMAINS (Deceased Person's Representative)				
12	FULL NAME	Print the full current legal name of the person including: first, middle and last name who is authorizing the facility to release the human remains.	X	X
13	PHONE #	Print the phone number for the person responsible for authorizing release of the human remains in numerical format: area code+ first three digits of number+ last four digits of number.	X	X
14	RELATIONSHIP TO DECEASED	Print the person's relationship to the decedent (i.e. spouse, mother, father, son, daughter, brother, etc.).	X	X
CURRENT CARE HEALTH CARE PROVIDER EXPECTED TO SIGN MEDICAL CERTIFICATION OF DEATH				
15	FULL NAME	Print the first, middle and last name of the practitioner that is expected to certify the cause of death.		X
16	PHONE #	Print the practitioner's phone number in numerical format: area code+ first three digits of number + last four digits of number.		X
17	FAX #	Print the practitioner's fax number in numerical format: area code+ first three digits of number + last four digits of number.		X
18	EMAIL ADDRESS	Print the practitioner's e-mail address as it appears: johnsmith@azdhs.gov		X
MEDICAL INFORMATION FOR DECEASED PERSON				
19	THE MOST RECENT DIAGNOSIS IN THE PERSON'S MEDICAL RECORD IS:	Print the most recent medical diagnosis for which the deceased person may have died as documented in their medical record.	X	X
20	INDICATE WHETHER THE DECEASED PERSON HAD BEEN DIAGNOSED WITH OR WAS SUSPECTED OF HAVING ANY OF THE FOLLOWING, AS STATED IN THE MEDICAL RECORD AT THE TIME OF DEATH	Check all conditions that apply to the deceased person. If the descriptions do not apply to the decedent, check the "None of the Above Apply" check box indicating that the decedent had not been diagnosed with or was not suspected of having any of the listed conditions.		X
INDICATE WHETHER THE DECEASED PERSON HAD BEEN DIAGNOSED WITH OR WAS SUSPECTED OF HAVING ANY OF THE FOLLOWING, AS STATED IN THE MEDICAL RECORD AT THE TIME OF DEATH				
21	LIST OF CIRCUMSTANCES	Circumstances in which notification must occur under A.R.S. §11-593.	X	X
22	WAS THE DEATH REPORTED?	Check one of the options (i.e. Yes, Spoke To___, No or Not Applicable-N/A)	X	X
23	HOSPITAL USE ONLY	If the deceased individual's human remains have been accepted for donation by an organ procurement organization under A.R.S. Title 36, Chapter 7, Article 3, and the person authorized in A.R.S. §36-843 has not made or refused to make an anatomical gift, indicate whether the organ procurement organization has been notified that the deceased individual's human remains are being removed from the hospital. Check one of the options (i.e. Yes, No)	X	X

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Field #	Field Name	Field Description	Fetal Death	Death
PERSON REPRESENTING THE FACILITY THAT RELEASED THE HUMAN REMAINS				
24	FULL NAME	Print the current legal name including: first, middle and last name – of the facility representative who is authorized to release the human remains from the facility. This person is responsible for verifying that fields 1-26 on the HRRF have been completed.	X	X
25	SIGNATURE	Signature of the facility representative listed in field 24.	X	X
26	DATE & TIME	Date and time of which the facility representative affixed the signature listed in field 25. Print the date in the format of MM/DD/YYYY and print the time. List the time indicator in one of the following formats: AM, PM (12-hour clock) or Military (24-hour clock) next to the printed time.	X	X
PERSON ACCEPTING CUSTODY OF THE HUMAN REMAINS				
27	FULL NAME	Print the current legal name including: first, middle and last name – of the person accepting custody of the human remains. This person is responsible for verifying that the facility representative has completed fields 24-26 before completing fields 27-29.	X	X
28	SIGNATURE	Signature of the custodian listed in field 27.	X	X
29	DATE & TIME	Date and time of which the custodian affixed the signature listed in field 28. Print the date in the format of MM/DD/YYYY and print the time. List the time indicator in one of the following formats: AM, PM (12-hour clock) or Military (24-hour clock) next to the printed time.	X	X
BUSINESS NAME OF ESTABLISHMENT ACCEPTING CUSTODY OF HUMAN REMAINS				
30	BUSINESS NAME	Print the business name of the establishment accepting custody of the human remains (i.e. Funeral Home, Me, Donation Facility). **Important Information for the Business Establishment**: The business establishment listed in field 30 must submit the accurately completed and signed HRRF form to the County Vital Records Office within 24 hours of taking possession of the human remains (A.R.S. 36-326(C)). Note: The Funeral Home shall upload the HRRF form in the death record in the DAVE system then, enter the date that the HRRF was signed (date the Funeral Home took possession).	X	X
31	HOSPITAL STICKER	Area on the form where the facility can place the patient label. Use of this area is optional and is not required.		

The facility where the decedent expired is expected to have the HRRF form completed in advance of the contracted transport service pick up. The facility shall ensure the transport service completes fields 27-30 on the HRRF form.

If you have questions regarding this form, please contact the ADHS BVR Support line at 602-364-2230.