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www.autopsypc.com

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5525 Meat Camp Rd.
Todd, NC 28684

AUTHORIZATION FOR AUTOPSY

Section 1.

Name of Deceased: ____

Date of Birth: ____

Date of Death: ____

Location of Death: ____

Section 2.

The following people, in the order listed below, are authorized to give permission for an autopsy.

I am the deceased's:

_____ Healthcare agent and the healthcare power of attorney

_____ Spouse

_____ Adult child or stepchild

_____ Parent or stepparent

_____ Adult brother or sister

_____ Guardian

_____ Relative who accepts responsibility for disposing of the body

_____ Any other person obligated to dispose of the body

Section 3.

_____ I authorize Autopsy PC to remove and examine organs, tissues, fluids, and devices from the body. This is to determine the cause/manner of death, collect evidence and/or establish a photographic record of findings. I give permission for Autopsy PC to retain and to dispose of body parts. Body parts will not be released to any entity other than a licensed medical professional or a licensed funeral home. I also understand that I can limit which body parts are removed, examined or kept. I know that if I decide to limit the autopsy, it may make it harder, or even impossible, to determine why to deceased died. I understand that sometimes the cause/manner of death cannot be determined even though an autopsy was performed. I hereby specify that the autopsy examination will be:

_____ Complete examination of the head, chest, abdomen, pelvis and extremities

_____ Examination limited to the ______________________________ (head; chest; abdomen; etc.) only

_____ Other restrictions or special instructions ____

Section 4.

_____ I further authorize the release of information to Autopsy PC regarding any treatment the deceased may have received from any hospital or medical provider.

Name and location of decedent's physician ____

Site(s) of hospitalization ____

Section 5.

Please enter below a medical history for the decedent. (for example high blood pressure, diabetes, etc.):

Section 6.

Please enter the medications the decedent was taking:

Section 7:

Please enter below a short clinical history of what occurred to the decedent prior to his or her passing:

Section 8.

Please enter below the name, address and phone number of the funeral home and the name of the funeral director who has been assisting you:

Section 9.

What do you want to learn from the autopsy?

Section 10.

_____ I understand that preliminary findings will be available within 7 days of the procedure and the final report will take at least 8 weeks.

Section 11.

_____ I understand that provisional or final results will not be released until payment is made in full.

Section 12.

_____ I understand that the best way to communicate with Autopsy PC is via email (bhall@paboone.com).

Section 13.

I am at least 18 years old. I acknowledge that I have read this document, understand the content of this form, have had the opportunity to ask questions, all my questions have been answered to my satisfaction, and that all requested information has been completed. I sign this form voluntarily.

Signature of Next of Kin/Power of Attorney: ______________________________

Print Name: ______________________________

Date: ____________________ Time: ____________________

Phone number: ____________________ Email: ____________________

Mailing address: ______________________________

Witness: ______________________________