POST-MORTEM EXAMINATION AUTHORIZATION

Decedents Name: ___________________________ Exam Type: Full Autopsy / Partial Autopsy
Organ Removal / Toxicology Only

CONSENT FROM LEGALLY AUTHORIZED PERSON

I certify that I _______________________________ (Print Name), am the _____________________ (Relationship) of the decedent and I have accepted* the remains for the purpose of burial or cremation. I hereby authorize PathCare, PLLC to perform the above chosen examination and as such, give permission to remove organs and/or tissues as deemed necessary along with any body fluids for the purpose of special analysis or testing, unless otherwise restricted in writing as indicated below.

I authorize the retention and ultimate disposal of organs, tissues, body fluids, prosthetic and implant devices, for diagnostic or scientific use according to established guidelines and regulations.

*Note: When two (2) or more legally authorized persons assume custody, the consent of one person shall be sufficient to authorize such examination(s).

(Restrictions): ____

TRANSPORTATION AUTHORIZATION

I authorize any cemetery authority, licensed funeral director or health facility, having custody of the remains, to permit the release of the remains, including transportation to/from such facility in order to complete the above selected examination. Any and all costs associated with the transportation of the remains will be paid separately by the person authorizing transportation.

CERTIFICATION OF AUTHORIZATION

As indicated above, I am the legally authorized person having the authority to authorize all of the services contained herein and give such permission to PathCare, PLLC to perform or have performed the agreed services.

Signed this ____ (Numeric) day of _______________ (Month), ______ (Year) in witness of _______________________________________ (Printed Name of Witness).

___________________________________ ___________________________________
(Signature of Legally Authorized Person) (Signature of Witness)