



PATHOLOGY
SUPPORT
SERVICES, INC.

Authorization for Autopsy And Release of Medical Records,

I, _____
DECLARE, UNDER PENALTY OF PERJURY, that I am the legal next kin
and have the right to authorize Pathology Support Services, Inc. to
perform an autopsy and retain tissue without restriction on the remains of
(deceased legal name) _____ (Date of
Birth) _____.

I understand this autopsy will include a gross and microscopic
examination and description of all major organ systems of the decedent.
The fee for this procedure is _____.

I understand this autopsy fee DOES NOT include any TOXICOLOGY TEST,
MICROBIOLOGY TEST, SPECIAL NEUROLOGICAL or DNA STUDIES.

I understand that it will take approximately forty-five working days before an
Autopsy Report is completed. I also understand we will need medical records to
review before we can complete a report.

Name of Funeral Home: _____

Autopsy Date:

Authorized Person (print name) _____

Authorized Signature: _____

Date: _____

Enclose a copy of this form with payment, or if paying by credit card, please fax
this over to us.

We accept VISA & MasterCard, call us with your information, please for security
do not email this information. If you are using a personal check, please write
your Driver's License information and phone number on the front of the check
and make check payable to:

Pathology Support Services, Inc.

P.O. Box 163450

Sacramento, CA 95816-9450

916-732-2450

916-732-2458 Fax