AUTHORIZATION FOR AUTOPSY
REQUESTED BY FAMILY

I request and authorize SouthEastern Pathology, P.C. to perform an autopsy on the remains of: _____. I authorize the removal, disposal, and retention of such organs, tissues and parts as are at SouthEastern Pathology's discretion deemed proper for diagnostic, scientific or therapeutic purposes.

I understand that services will be performed as indicated below:

☐ Trunk Only ☐ Head Only ☐ Complete ☐ Abdomen ☐ Other *Specify Below*

SPECIAL INSTRUCTIONS:_____

_____

I understand that the fee for this service is $4,200 payable in advance and that services will be performed only upon payment of the fee. I also understand that in the event additional studies are required, I may be invoiced for these additional services and that fees for all services must be paid in full prior to receiving an autopsy report.

After the autopsy, I wish the remains to be released to:

_____

Name of Funeral Home City/State Phone #

I certify that I am the _____ of the deceased and entitled by law to control the disposition of the remains.

Signature	Address
Printed Name	City/State/Zip Code
Date	Phone #

SIGNED IN THE PRESENCE OF:

Witness Signature	Witness Printed Name	Date

Document #: 112113