CLINICAL RECORD	AUTHORIZATION FOR AUTOPSY

In the event authorization for autopsy is obtained by letter, telegram, voice recorded or monitored telephone call, paragraphs 1, 2, and 3 shall be completed by medical facility authorities and the letter, telegram, voice recording or memorandum confirming telephone call of authorization attached to this form for permanent file.

1. NAME AND LOCATION OF MEDICAL FACILITY	DATE AND TIME

2. I (We) request and authorize the physicians in attendance at the above named medical facility to perform a complete autopsy on the remains of _____ _____. I (We) understand that a complete autopsy may include, but not be limited to, examination of the head, eyes, spinal cord, chest, abdomen and extremities unless excluded under restrictions hereinunder, and I (We) authorize the removal and retention or use for diagnostic, scientific, or therapeutic purposes any parts, tissues, or organs as such physicians or their designees may deem proper, and the final disposal thereof in such manner as may be prescribed by competent authority (Commanding Officer, Medical Director, etc.) in this facility.

This authority is granted subject to the following restrictions: _____

_____

_____

_____

(If No Restrictions, Write "None")

The following special examinations are requested: _____

_____

_____

3. I (We) represent that I am (we are) the _____
(Relationship/Authority)

of the deceased and entitled by law to control the disposition of the remains.

Signed _____

WITNESSES (medical facility staff members):

Signed _____

Signed _____
(Name and Title)

Signed _____
(Name and Title)

FOR ADMINISTRATIVE USE ONLY

Case falls within jurisdiction of Medical Examiner/Coroner . . . . . YES ☐ NO ☐

Medical Examiner/Coroner released remains from his jurisdiction to this authority . . . . . YES ☐ NO ☐

SIGNATURE	TITLE	DATE

PATIENTS IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; medical facility)*	REGISTER NO.	WARD NO.

AUTHORIZATION FOR AUTOPSY
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