PROVIDENCE Health Care

AUTHORIZATION TO PERFORM AUTOPSY

- THIS FORM IS NOT TO BE USED FOR PRIVATE PAY AUTOPSIES.
- PLEASE FAX IMMEDIATELY TO THE PATHOLOGY DEPARTMENT AT PSHMC AT 509-474-2052 TO COORDINATE AUTOPSY (Also provide a copy of this form to the Funeral Home indicated below)
- IF THE DECEASED IS NOT IN EPIC, PLEASE ALSO COMPLETE AND FAX A 'DEATH PROCEDURES FORM'

NAME OF DECEASED _____ AGE _____ SEX _____

ATTENDING/AUTHORIZING PHYSICIAN _____ CONTACT # _____

DATE OF DEATH _____ TIME OF DEATH _____ AM/PM

1. I request and authorize the Pathologists and/or Pathologist's Assistants in the Pathology Department for PHC to perform a complete autopsy on the deceased and I authorize the removal and retention or use for diagnostic, scientific or therapeutic purposes of such organs, tissues and parts as such Pathologists deem proper.
2. I state that I am the LEGAL CLOSEST OF KIN (the order of legal closest of kin is as follows – check only one)
   - ☐ Surviving spouse or registered domestic partner
   - ☐ An adult child; AND THERE BEING NO SURVIVING SPOUSE, and all other children, if any, are in mutual consent
   - ☐ A parent; AND THERE BEING NO SURVIVING SPOUSE OR CHILD
   - ☐ An adult brother or sister; AND THERE BEING NO SURVIVING SPOUSE, CHILD OR PARENT
   - ☐ A next of kin, having the responsibility for burial; AND THERE BEING NO SURVIVING SPOUSE, CHILD, PARENT OR SIBLING
   - ☐ A person having the responsibility for burial; AND THERE BEING NO SURVIVING SPOUSE, CHILD, PARENT, SIBLING, OR NEXT OF KIN
3. This authority is subject to the following restrictions (if no restrictions, write 'NONE'):
   _____
4. The following special examinations shall be made:
   _____
5. I wish the remains to be released to the following funeral home:
   _____
   (Funeral Home) (City) (State)

Legal Next of Kin Signature: _____ Date: _____ Time: _____AM/PM

Ordering Physician Signature: _____

Witness: _____

Title: _____

Patient Identification Label