# YORK PATHOLOGY ASSOCIATES
# AUTHORIZATION FOR PRIVATE AUTOPSY

Name of Deceased _____ Age/Date of Birth _____ Sex _____

Date of Death _____ Time of Death _____

I, (printed name) _____, the (relationship to the deceased) _____ of the deceased, _____, being the legal next of kin and entitled by law to do so, hereby authorize and request the pathologists of York Pathology Associates to perform an autopsy on the body of said deceased. I understand that any diagnostic information gained from the autopsy will become part of the deceased's medical record and will be subject to applicable disclosure laws and HIPPA requirements.

I understand that due care will be taken to avoid mutilation or disfigurement of the body. I authorize the removal, examination, and retention of organs, tissues, prosthetic devices, and fluids as the pathologists deem proper for diagnostic purposes. I further agree to the eventual disposition of these materials as the pathologists or the hospital determine or as required by law. I understand that organs and tissues not needed for the above purposes will be sent to the funeral home or disposed of appropriately.

I understand that limitations may be placed on the extent of the autopsy and on the retention of organs, tissue, and devices. I understand that any limitations may compromise the diagnostic value of and/or limit the usefulness of the autopsy.

Limitations: □ None. Permission is granted for a complete autopsy.
□ Permission is granted for an autopsy with the following exceptions and/or limitations:
□ No Central Nervous System (Brain) examined
□ Other: _____

_____

I understand that there will be a charge of **$4,000.00** for the cost of the autopsy, to be paid by the family. Cost of transport to and from the facility for autopsy will be the responsibility of the family.

Specialized testing may be requested for which additional charges apply. Please indicate below if you are interested in ordering any of these tests.

□ Blood toxicology testing ($350) □ Vitreous fluid electrolytes ($100) □ Spleen bacterial cultures ($600)

_____ _____ _____
Signature of person authorizing the autopsy Date Time

_____ _____
Signature of person obtaining permission Signature of Witness

_____ _____
Printed name of person obtaining permission Printed name of witness

**Piedmont Medical Center**
**Consent and Authorization for Autopsy**

Adopted from CAP Autopsy Performance and Reporting, 2nd Edition, 2003.