



Daniel L Schultz, MD
 President
 AP/CP/FP Board Certified Pathologist
 30+ years autopsy/consult experience
 7000+ career autopsies
 Licensed in California, Florida, Georgia,
 Michigan, Ohio and Virginia

THE
AUTOPSY
Doctor

American Academy of Forensic Sciences - Fellow
 Florida Association of Medical Examiners - Member
 National Association of Medical Examiners - Fellow

Phone: 727-639-1897
Fax: 813-830-7420
Email: Mschultz@theautopsydoctor.com
 www.TheAutopsyDoctor.com

Authorization for Case or Autopsy Review / Second Look

Payment for record review can be credit card, check or Zelle and received prior to the review. Address at bottom. Necessary time is estimated based on records submitted but could require additional time.

Info of Decedent: (print) Name:	Male / Female	Race: _____	Weight: _____ pounds
Birth Date:	Death Date:	Location of Death:	
Attorney Name (if applicable)		Phone:	
Recent Hospitalization? Where:	Doctor:	Phone:	City: Records requested? Yes/No
Primary care physician name:		Phone:	
Autopsy performed Where?		Date?	
By whom?		Contact info:	
Was toxicology done? Y / N X-rays? Y / N Samples retained and what?			
It's important that our forensic pathologist speaks to the original pathologist, do you agree? Yes / No			
Is loved one buried, cremated or being held in refrigeration and where?			
Medical History Overview: Smoking ever? Y / N Alcohol / Drug abuse ever? Y / N Explain: _____			

What are your questions/concerns: _____			

Items being submitted for review: (electronic files preferred) _____			

Need review by (Normally done within 2 weeks of payment unless rush is needed):			
<i>If review and discussion is under time paid for, reimbursed via check, minus cc fees, in 15 min increments.</i>			
SIGNATURES AND FINANCIAL RESPONSIBILITY (If second person financially responsible, include too.)			
Authorizer's Printed Name: _____			
Authorizer's Signature: _____ Date : _____			
Relation to the decedent being reviewed: _____			
Cell: _____ Home: _____ Email: _____			
Address if written report requested (Additional hour required): _____ Billing address: _____			