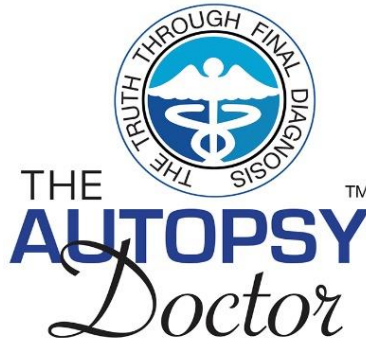


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Authorization for Medical Record Review

Payment for record review collected up front by credit card (4%)/check/ACH transfer/Zelle. Mailing address at bottom. Minimum of 1 hour for review, minimum 2 hour with report. A written report will be emailed as a pdf.

Name of Decedent: (print) Male / Female Ht: ____ Wt: ____ (If known)

Name: _____ Age: _____ Race: _____

Birth Date: _____ Date of Death: _____ Location of Death: _____

Attorney Name (if applicable) _____ Phone: _____

Autopsy performed? Yes / No Where? _____ Pathologist: _____

Permission to speak to pathologist: Yes / No Phone #: _____

Disposition of decedent currently. Stored: Y / N Where: _____

Buried: Y / N Embalmed: Y / N Cremated: Y / N

Circumstances/ Timeline/Recent surgery/Hospitalization:

Medications:

Medical History Overview: (Other known conditions)

What are your questions?:

Records being sent for review/Please request: _____

SIGNATURES AND FINANCIAL PARTY (Usually done within 2 weeks unless rush has been discussed)

Authorizer's Printed Name: _____

Authorizer's Signature: _____ Date : _____

Relation to the records being reviewed: _____

Cell: _____ Home: _____ Other: _____

Email for written report (if requested & paid for): _____

Billing address:

10% charged monthly on unpaid invoices for completed work.