



THE  
**AUTOPSY**<sup>TM</sup>  
*Doctor*

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**Authorization for Organ Recovery**

Payment is made up front. Transportation fees or room usage will be billed to requesting party. Final Diagnosis Inc. HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law. See "Procedures" for full statement.

Name of Decedent: (print) Male/Female Race:		Weight: _____ approx. pounds
		Age: _____
Birth Date:	Date of Death:	Location of Death:
Name of Funeral Home:		Contact Person:
Address:		Contact Phone:
Return to same facility? Yes / No If no, where are they being taken?		
Specific instructions: (Or attach instructions)		
_____		
_____		
_____		
_____		
Where and how will samples be sent:		
Has the Medical Examiner or Coroner been notified of death?: Yes / No County: _____		
Will decedent be embalmed after recovery? Yes / No Burial or cremation? _____		
<b>SIGNATURE AND FINANCIAL RESPONSIBILITY</b>		<i>(Include payee if different than authorizer)</i>
Next of Kin Printed Name: _____		Payee: _____
Sign and date: _____ / ____ / ____		Payee: X _____
<b>(Circle: Executor of estate, health care surrogate, spouse, adult child, parent, sibling, _____)</b>		
May also speak to: _____		Relation: _____ Phone: _____
Cell: _____ Home: _____		Email: _____
<b>Payee billing address:</b>		

10% monthly late fees after 30 days on unpaid balances on completed work.