



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

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**Authorization for Brain Neuro Study Only**

Payment for recovery paid upfront by requesting party by credit card (4%), direct BOA deposit, ACH or Zelle. Travel or site costs to be paid by requesting party. Special extra stains may be necessary for full workup and pricing will be shared in advance. Report is *usually* completed within 120 days. Brain must be retained. Final Diagnosis Inc. HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law. See "Procedures" for full statement.

Info of Decedent: (print)	Male / Female	Race: _____	Weight: _____ pounds
<b>Name:</b>			Age: _____
Date of Birth:	Date of Death:	Time of death:	
Location of death: _____			
Funeral Home Name:		Contact Person:	
Address:		Contact Phone:	
Known diagnosis/year: _____			
Neurologist:		Phone: _____	
Primary Dr.:		Phone: _____	
Medical History: _____ _____ _____			
Specific Instructions: _____ _____ _____			
Has a Medical Examiner or Coroner been notified of death?: Yes / No			
<b>Covid-19 status:</b> Pos / Neg (Circle one)    Date of test ___ / ___ / ___    Vaccinated for Covid: Yes / No			
Decedent: ___ Is embalmed ___ will be embalmed after recovery    Burial or Cremation (circle one)			
<b>SIGNATURES 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:</b> Executor of estate, health care surrogate, spouse, adult child, parent, sibling, _____)			
Cell: _____		Home: _____	
		Email: _____	
May also speak to: _____		Relation: _____	
		Phone: _____	
<b>Payee billing address:</b> _____ _____			
10% monthly late fees after 30 days on unpaid balances on completed work.			