



THE AUTOPSY Doctor™

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Authorization for Forensic Case Review

Fees discussed collected up front by credit card (4%), check, ACH, BOA counter deposit or Zelle. Mailing address at bottom. Necessary time is estimated based on records submitted but could require additional time. Final Diagnosis Inc. HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law. See "Procedures" for full statement.

Decedent: (print) Male / Female Ht: ____ Wt: ____ = BMI ____ (35 is \$250, 40 is \$500, 45 is 750, each 5 is +\$250)		
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 (Where?) _____		
Circumstances/ Timeline: _____ _____ _____ _____ _____		
What are your questions?: _____ _____ _____ _____		
Records being sent for review: _____ _____		
Need reviewed by (Usually within 2 weeks of payment unless rush is needed): _____		
*MAY also speak to: _____	Relation: _____	Phone: _____
SIGNATURES AND FINANCIAL RESPONSIBILITY		(Include payee if different than authorizer)
Authorizer Printed Name: _____		Payee: _____
Sign and date: _____ / ____ / ____		Payee: X _____
**Relation to the records being reviewed: _____		
Cell: _____	Home: _____	Other: _____
Email (If report paid for): _____		
Payee billing address: _____		

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