



# THE AUTOPSY Doctor™

Phone: 727-639-1897  
 Fax: 813-830-7420  
 Email: [Mschultz@theautopsydoctor.com](mailto:Mschultz@theautopsydoctor.com)  
[Dschultz@theautopsydoctor.com](mailto:Dschultz@theautopsydoctor.com)  
[www.TheAutopsyDoctor.com](http://www.TheAutopsyDoctor.com)

### 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. 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 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.		