MUNSON HEALTHCARE

Physician Authorization / Request for Autopsy

Patient Label

Date:_____

Time:_____

I, _____request an autopsy to be performed at

Munson Medical Center on:

_____

Deceased name: Last First Middle Initial

_____ and _____

Deceased patient's Medical Record Number Date of Birth

Physician Signature:_____

Copy of report to: _____

(Send a copy of this completed form to Pathology)