

**AUTHORIZATION  
FOR AUTOPSY**

Patient Name:  
Medical Record #:  
Date of Birth:

I request and authorize the physicians in attendance at University of Kentucky Hospital, Chandler Medical Center to perform an autopsy on the remains of:

\_\_\_\_\_  
Patient's Name

and I authorize the removal and retention or use for diagnosis, scientific, educational or therapeutic purposes of such organs, tissue and parts as such physicians and surgeons deem proper.

Permissions:  Complete autopsy (including head)

Brain Only  Abdomen only  Chest only  Chest and Abdomen only  Other instructions: \_\_\_\_\_

**Retention of Organ/Tissues:**

I give my consent to the autopsy service to conduct an extended whole organ examination on the brain and/or spinal cord or other internal organ(s) as noted above with preparation of microscopic slides, Because of this examination, I understand that the body may be released to the funeral home without the brain and/or spinal cord or other organ(s). I agree to the retention of the brain and/or spinal cord or other organs in a special solution (formalin) for several weeks to enable examination by a neuropathologist or other specialist.

\_\_\_\_\_ initial here to agree

I consent to the autopsy service removing, using and retaining diagnostic samples and extra tissue, including organs, for research, teaching, and quality control (for improving the quality of laboratory testing procedures and other aspects of medical care).

\_\_\_\_\_ initial here to agree

All retained organs and tissues will be handled with respect and given an appropriate disposition when no longer required for the purposes noted above. If necessary, medical cremation with no residual ashes will be performed at no expense to the decedent's family. Specimens will have no identifying information and therefore cannot be specifically retrieved. If used for research, teaching, or medical publication, the patient's identity will not be revealed.

\_\_\_\_\_  
Signature of Person Giving Authorization

Relationship and legal authority, must be one of the following:

- Spouse<sup>1</sup>
- Children<sup>2</sup>, grandchildren<sup>3</sup>, great-grandchildren<sup>4</sup>, brothers and sisters<sup>5</sup> (age 18 or over)
- Father and/or Mother<sup>6</sup>
- Nieces and nephews<sup>7</sup>
- Grand nieces and nephews<sup>8</sup>
- Maternal and paternal grandparents<sup>9</sup>
- Uncles and Aunts and their descendants<sup>10</sup>
- Great-grandfathers and great-grandmothers<sup>11</sup>
- Brothers and sisters of great-grandfathers and great-grandmothers<sup>12</sup>
- Or Legal representative

\_\_\_\_\_  
Address of Person Giving Authorization

\_\_\_\_\_  
WITNESS (physician or person security authorization)

\_\_\_\_\_  
Date of Signature

Coroner case:  Yes  No

\_\_\_\_\_  
Name of Funeral Home

Coroner's Office Notified:  Yes  No

\_\_\_\_\_  
Address of Funeral Home (if know)

Clinician(s) to be paged  
when autopsy begins:

Attending physician: \_\_\_\_\_

Pager #: \_\_\_\_\_

Residents: \_\_\_\_\_

Pager #: \_\_\_\_\_

**PATHOLOGY DEPT.**

Autopsy completed and Admitting Office notified:

Date:

Time:

AM  
 PM