



Louisiana State University Medical Center - Shreveport
Pathology Outreach Services

AUTHORIZATION FOR AUTOPSY

Date _____ Time _____ A.M. / P.M.

I request and authorize the physicians and surgeons in attendance at the Louisiana State University Medical Center to perform a complete autopsy on the remains of _____ and I authorize the removal and retention for study or use for diagnostic, scientific, or therapeutic purposes of such organs, tissues, and parts as such physicians and surgeons deem proper. I understand that parts or all of the autopsy may be observed by Physicians, Medical Students, or Students in Laboratory Technology, Nursing, or other related fields, and that some or all of the internal organs may be kept by the hospital for teaching purposes.

Type of autopsy: *(please check one)* _____ Private _____ Medical _____ Forensic

This authority is granted subject to the following: *(please check one and specify if indicated)*

_____ Complete Autopsy

_____ Limited Autopsy *(specify restrictions)* _____

The following special examinations are requested: _____

RELEASE OF REMAINS

I wish the remains to be released to:

_____ (Name of Funeral Home) _____ (City, State)

I represent that I am the immediate next of kin of the deceased and entitled by state law to control the disposition of the remains. *(Indicate relationship to deceased)* _____

Signed: _____ Witness: _____

Signed: _____ _____

Authorization for Release of Autopsy Results to Other Individual or Institution

I authorize the results of the autopsy to be released to the following individual or institution:

Name of Individual / Institution to Receive Copy: _____

Signed: _____ Witness: _____

Date: _____ Witness: _____