Providence
Sacred Heart
Medical Center

AUTHORIZATION TO PERFORM AUTOPSY

- **Please fax immediately to the Pathology Department at PSHMC, (509) 474-2052 to coordinate autopsy. Also provide a copy of this form to the funeral home indicated below.**
- **If the deceased is not in Epic, please also complete and fax a "Death Procedures" form.**
- **Physician EPIC order code: Fetal Demise (Lab 0302) Pediatric/ Adult (Lab 2457)**

Name of Deceased _____ **Age** _____ **Sex** _____

Attending/Authorizing Physician _____ Contact# _____

Date of Death _____ **Time of Death** _____ **AM/PM**

1. I request and authorize the pathologists and/or pathologist's assistants in the Pathology Department for PHC to perform a complete autopsy on the deceased, and I authorize the removal and retention or use for diagnostic, scientific or therapeutic purposes of such organs, tissues and parts as such pathologists deem proper.

2. I state that I am the **legal closest of kin.** The order of legal closest of kin is as follows (check only one):

   - ❑ Surviving spouse or registered domestic partner
   - ❑ An adult child; **and there being no surviving spouse,** and all other children, if any, are in mutual consent
   - ❑ A parent; **and there being no surviving spouse or child**
   - ❑ An adult brother or sister; **and there being no surviving spouse, child or parent**
   - ❑ A next of kin, having the responsibility for burial, **and there being no surviving spouse, child, parent or sibling**
   - ❑ A person having the responsibility for burial, **and there being no surviving spouse, child, parent sibling, or next of kin**

3. This authority is subject to the following restrictions (If no restrictions, write "NONE"):

   _____

4. The following special examinations shall be made:

   _____

5. I wish the remains to be released to the following funeral home:

   _____
   (Funeral Home) (City) (State)

Next of Kin Signature: _____ Date: _____ Time: _____ AM/PM

Witness (Medical Staff): _____ Title: _____
(*one witness if completed in person)*
Witness (Medical Staff): _____ Title: _____
(two witnesses if completed over the phone)

Patient identification label

NS1312 Rev 1/24

Copy: Chart, Pathology Lab, Funeral Home