PathServe Autopsy

PO BOX 16510
San Francisco, CA 94116
Phone (415) 664-9686
Fax (415) 900-4022
e-mail: info@autopsy.biz

Dear Valued Client:

We understand that this is a stressful time, and we offer our sympathies.

We promise to treat your loved one with dignity and respect. Our staff consists of licensed physicians, **board-certified** in Anatomic, Forensic and Clinical Pathology. We will provide you with a **preliminary verbal report** within 24-48 hours of performing the autopsy. You will receive a concise, easy-to-read, **written report** within 4-5 weeks.

In addition, our pathologists will provide you with **unlimited consultation** by phone. We are committed to answering all your questions fully and in language you can understand.

It is our standard policy to ask for a payment **prior to** performing the autopsy. Thank you for your attention to this matter. And again, may we offer our sympathies.

Please make checks payable to **PathServe.**

Cost for a complete autopsy is $3400. Out of Bay Area we charge $40 per hour travel reimbursement.

Additional tests, such as toxicology or immunostains are client's responsibility and cost $100 to 300 per panel.

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AUTOPSY PERMIT

DATE: _______________

In the hope and with the expectation that this permission will contribute to the advancement of medical knowledge, I, as the next-of-kin or person authorized by law to direct disposition, authorize a complete post-mortem examination (autopsy) by PathServe Autopsy Business on the remains of

____
(NAME)

Permission is hereby granted for the release of any medical information including hospital records.

I understand that a complete post-mortem examination may include external and internal examination of the head, eyes, temporal bones, spinal cord, chest, abdomen and extremities unless specifically excluded, and I authorize the removal and retention for diagnostic purposes of such organs, tissues and parts as such prosector deem proper.

There are no restrictions regarding this authorization except as listed below:

____

____________________ ____________________ ____________________
SIGNATURE LEGAL NEXT-OF-KIN PRINT NAME RELATIONSHIP

____
ADDRESS CITY STATE ZIP

____
WITNESS

* Funeral arrangements can proceed as planned. Families who wish an open viewing can do so.
* Confidential autopsy report will be mailed to the address above.

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Guarantor information:
I am responsible for the autopsy cost.

Name ____________________________ Phone __________________________

Address (if different from above)
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Signature ____

Autopsy Information Sheet

Decedent Name________________________________ Date of Birth______________

Principal Diagnosis/ Cause of Death (if known):

Summary of Clinical Course (please include relevant tests and imaging studies):

Specific Questions to be answered by Autopsy: