



NEBRASKA FORENSIC MEDICAL SERVICES, P.C.

AUTHORIZATION FOR AUTOPSY

Date: _____

I, _____, bearing the relationship of _____ to _____, a patient recently deceased, hereby authorize a pathologist of Nebraska Forensic Medical Services, P.C. to make as complete an examination of said deceased and removal of such tissues as may be necessary to determine the cause of death.

AUTOPSY RESTRICTIONS:

- | | |
|---|---|
| <input type="checkbox"/> No Restrictions | <input type="checkbox"/> Head and Neck Only |
| <input type="checkbox"/> Abdomen Only | <input type="checkbox"/> Heart Only |
| <input type="checkbox"/> Brain Only | <input type="checkbox"/> Neck Only (muscles, larynx, trachea, tongue) |
| <input type="checkbox"/> Brain and Spinal Cord | <input type="checkbox"/> Pelvis Only (bladder, ovaries, uterus, prostate) |
| <input type="checkbox"/> Chest and Abdomen Only | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest Only (heart and lungs) | Photography <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Toxicology <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Histology <input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature of Next of Kin or Legal Representative

Relationship

Witness

Witness