



Name

MR#:

DOB:

N/S:

Service/Doctor:

## **CONSENT TO AUTOPSY**

### **Explanation of the Procedure**

An autopsy is a medical and scientific procedure. Its purpose is to find out the cause of death. Autopsies may also help people who are still alive, because they may add to our understanding of medicine and public health issues.

The medical procedure for autopsy requires surgical incisions to allow observation and removal of organs. These incisions do not involve the face or other parts of the body that are visible when the body is clothed.

An important part of an autopsy involves examination and testing of body tissues, fluids and any mechanical devices or equipment that were in or on the body during life. In order to complete this testing, the medical center keeps tissue and whole organs for further examinations and study.

While it is possible, upon special request, to perform a limited autopsy, the findings and results of such an autopsy may be of limited value. As a result, these limited autopsies are not recommended by pathologists, except in special circumstances.

### **Consent and Authorization for Autopsy**

I, \_\_\_\_\_, certify that I am:  
(Print name)

- |   |   |
|---|---|
| 1. <input type="checkbox"/> The spouse or registered domestic partner | 4. <input type="checkbox"/> A parent  |
| 2. <input type="checkbox"/> A son or daughter over the age of 18      | 5. <input type="checkbox"/> An aunt or uncle over the age of 18 or a grandparent    |
| 3. <input type="checkbox"/> A grandchild over the age of 18           | 6. <input type="checkbox"/> Any other person entitled by law to dispose of the body |

I certify that I know of no opposition to autopsy by the deceased or by any next-of-kin of closer relationship to the deceased than myself.

I request that the pathologists of SUNY Downstate Medical Center perform an autopsy on the body of the deceased.

I understand that the results of the autopsy will become part of the deceased's medical record and that I may request a copy of the report when it is complete.



Name \_\_\_\_\_

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## **CONSENT TO AUTOPSY**

I agree to allow SUNY Downstate Medical Center to remove, examine and keep organs, tissues, fluids and prosthetic and implantable devices for further diagnosis, study, education and research as the pathologists think appropriate. I also agree to allow the hospital to dispose of these materials according to hospital procedures and the law.

I understand that I may place limits on the autopsy, but that these limits may affect the value and usefulness of the findings.

### **Limitations and Special Instructions**

- ☐ None. I am requesting a complete autopsy.
- ☐ I am requesting an autopsy to be performed with the following limitations or instructions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Print name) (Signature) (date) (time)

\_\_\_\_\_  
(Print name) (Signature) (date) (time)

\_\_\_\_\_  
(Print name) (Signature) (date) (time)

***WITNESS: I have witnessed the next-of-kin sign this form.***

\_\_\_\_\_  
Witness's Name (Print) (Signature) (Date)

***INTERPRETER: I have interpreted truthfully and accurately to the best of my ability***

\_\_\_\_\_  
Interpreter's Name (Print) (Signature) (Date)

Approved by: \_\_\_\_\_  
(Administrator) (Date)