SAN MATEO COUNTY CORONER'S OFFICE
Robert J. Foucrault, Coroner
225 37th Avenue, 3rd Floor, Suite A31, San Mateo, CA 94403
Phone (650) 312-5562 Fax: (650) 571-6258

Private Autopsy Request

Decedent Information

Deceased Name: ____

Date of Death: ____________________ **Location of Death:** ______________________________

Requesting Person(s) *(must be all legal next of kin or authorized durable power of attorney for healthcare)*

Name: ____

Relationship to Deceased: ______________________________ ☐ **Legal Paperwork Provided**

Address: ____

Phone: ___________________________ **Alternate:** ___________________________________

Authorization:

☐ I am the person(s) authorized by law to direct disposition of the remains of the above-named deceased. *Initials*______________

☐ I authorize the examining Forensic Pathologist to remove tissues, organs and/or other specimens, and to preserve and/or contribute the same for such diagnostic, therapeutic or other scientific purposes as the San Mateo County Coroner shall deem appropriate. *Initials*______________

☐ I authorize the Coroner and examining Forensic Pathologist to receive medical information for the above named deceased pursuant to California Civil Code §56.10(b)(8). *Initials*______________

☐ I understand the base fee for the autopsy is $3,675.00 and the fee shall be paid prior to the start of any investigation or autopsy. *Initials*______________

☐ I understand it will be my responsibility to pay for any and all testing (in addition to the base fee) the Coroner requests in an effort to determine the diagnosis of death. *Initials*______________

This authorization is in accordance with California Government Code §27520 and the fee set forth in Ordinance No. 03587, Board of Supervisors, County of San Mateo, State of California.

Signed: ____ **Date:** ___________________

Witness: ____ **Date:** __________________

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General Information

Name of the Deceased:	
Date of Death:	**Date of Birth:**
Reported to this office at time of death? Yes ☐ No ☐	**Case Number:**

Physician Information

Primary Care Physician

Name:			
Address:	**City:**	**State:**	**Zip:**
Phone: (home)	**(work)**	**(cell)**	

Specialist / Other:

Name:			
Address:	**City:**	**State:**	**Zip:**
Phone: (home)	**(work)**	**(cell)**	

Specialist / Other:

Name:			
Address:	**City:**	**State:**	**Zip:**
Phone: (home)	**(work)**	**(cell)**	

Hospitalizations / Medical Facilities

Hospital:	**Medical Record #:**
Hospital:	**Medical Record #:**
Hospital:	**Medical Record #:**