



2761 SULLINS STREET KNOXVILLE TN 37919 P 865.215.8000 F 865.215.8001

REQUEST FOR AUTOPSY REPORT

TODAY'S DATE: _____

LEGAL NAME OF DECEASED: _____

DATE OF BIRTH: _____ DATE OF DEATH: _____

NAME OF PERSON REQUESTING AUTOPSY
REPORT: _____

SEND REPORT TO:

NAME: _____

STREET: _____

CITY, STATE, ZIP: _____

PLEASE ATTACH A COPY OF YOUR PHOTO IDENTIFICATION

RETURN TO FAX: 865.215.8001

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For Office ONLY.

Rec'd _____
Initials

Date _____

Date Mailed _____