



Midwest Medical Examiner's Office

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Accredited by



AUTOPSY PHOTOGRAPH RELEASE FORM

I, _____ am requesting of Midwest Medical Examiner's Office send me a copy of a postmortem photograph(s) of:

Name of decedent _____

In consideration of and as a condition to my being permitted to obtain the photograph(s), I voluntarily, knowingly and irrevocably assume any and all associated risks, known and unknown, associated with the viewing, including but not limited to the possibility of present or future emotional distress.

I hereby release and hold harmless Midwest Medical Examiner's Office and its directors, officers, employees and agents from any and all liability. I understand that this agreement will apply even if the injury or damages result from negligence or failure to warn on the part of Midwest Medical Examiner's Office.

I have had an opportunity to have my questions answered by a Midwest Medical Examiner's representative.

Signature of person obtaining photograph(s)

Signature of witness

Printed name of person obtaining photograph(s)

Printed name of witness

Address/City/State/Zip Code

Telephone

Date

Retention: Decedent's File