



# TRAVIS COUNTY MEDICAL EXAMINER



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CHIEF MEDICAL EXAMINER

## REQUEST FOR AUTOPSY REPORT

Date of Request: \_\_\_\_\_ CASE #: \_\_\_\_\_

Name of Decedent: \_\_\_\_\_ Date of Death: \_\_\_\_\_

Requested by: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Relationship to decedent: \_\_\_\_\_

or

Business/organization: \_\_\_\_\_

Please choose one of the following options for receiving the report:

Mail to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fax to: \_\_\_\_\_

Email to: \_\_\_\_\_