REQUEST FOR COPY OF RECORD

**TO:** Michigan Institute Of Forensic Science & Medicine

4707 McLeod Dr East

Saginaw, Michigan 48604

Telephone & Fax (989)-341-5077

**I Request**: (Check appropriate Item(s) :

\_\_ Inspect

\_\_ Make memorandum, abstract or handwritten copy

\_\_ To **Receive** a copy of the following Records

***(Please check (X) the appropriate Box)*** \_\_***AUTOPSY REPORT*** \_\_***LAB/TOXICOLOGY*** ***REPORT***

***\* \* Next of Kin will receive one copy of requested reports at NO cost)***

**Name of Deceased**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Print Your Name**  **(Signature of Person making Request)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address Relationship to Deceased or Department**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip Phone Number**

**Copy of identification attached \*\*\*(COPY IS REQUIRED TO RELEASE RECORDS)**

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

**Request Completed By: Date Mailed/Faxed/Completed**