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)**

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