Autopsy Center of Chicago
www.autopsychicago.com
855-8-AUTOPSY
info@autopsychicago.com

AUTHORIZATION FOR POSTMORTEM TUMOR OR TISSUE DONATION FOR RESEARCH PURPOSES

Section 1. Today's Date:_________________ Name of Deceased:_____________________________________

Age:_____ Date of Birth: ____________Date of Death: _____________Time of Death (if known):_______am/pm

Location of Death:_______________________Name of Family Physician:_________________________________

Section 2.

I, ____, being legal next of kin or court-appointed Power of Attorney for Health Care, hereby authorize Dr. Ben Margolis (or physician of his designation) to perform an autopsy on the body of the deceased. I represent that my relationships to the deceased is: ____________________________ (husband/wife, sister/brother, father/mother, etc).

Section 3.

I hereby specify that the autopsy examination will be:

☐Complete examination of head, chest, and abdomen
☐Examination of chest and abdomen only
☐Examination of chest only
☐Examination of head only
☐Examination of abdomen only
☐Other restrictions or special instructions (**if none, write "none"**):________________________________

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Section 4.

Authorization is further granted for removal, retention, use (for diagnostic or teaching purposes such as Dr. Margolis may deem appropriate) and disposal of any organs (to include but not limit to organs of the abdominal, thoracic, and cranial cavities). See also Section 5.

Authorization is further granted for taking, use and publication of photographs for educational and scientific (including research) purposes, provided the identity of the body is protected.

Authorization is further granted for observers to witness the autopsy such as Dr. Margolis may deem appropriate, provided the purpose of the observation is for the advancement of scientific education.

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AUTHORIZATION

Section 5. Donation of Tissue for Research

A. The tissue can be distributed to different kinds of researchers.
I authorize Autopsy Center of Chicago ("ACC") to retrieve tissue ("donated tissue") from the deceased ("donor") and distribute the donated tissue to a "recipient" for research purposes. The term "tissue" refers tumor tissue, healthy tissue, or otherwise diseased tissue. A "recipient" is hereby defined as a facility engaged in scientific research, including but not limited to academic institutions, biotechnology companies, pharmaceutical companies, and ACC, itself. I authorize ACC, at its sole discretion, to select the recipient or recipients of the donated tissue. I understand that the donated tissue may be distributed to more than one recipient at the sole discretion of ACC.

__I authorize and understand **__I do not authorize**

B. The donated tissue will be used to help advance medicine.
I authorize ACC to release donated tissue to the recipient(s) and understand that the purpose of such release of tissue is for the advancement of medical science, including but not limited to the prevention, diagnosis and treatment of disease.

__I authorize and understand **__I do not authorize**

C. The recipient may study the DNA or other genetic information in the tissue.
I authorize ACC to release donated tissue to the recipient(s) and understand that the recipient may study the DNA or other genetic information or material in the tissue. This study of DNA or other genetic information or material is herein defined as "genetic testing." I understand that genetic testing of the tissue will not be done in a way to identify me or the donor's family.

__I authorize and understand **__I do not authorize**

D. The family's privacy is protected.
I authorize ACC to release the donated tissue to the recipient(s) and understand that my or the donor's personal, identifying data (as defined under standard HIPAA law), will not be disclosed in any manner to any recipient other than Autopsy Center of Chicago itself. I understand that, after release of my or the donor's de-identified health information, the health information will not be used to identify me or the donor. I understand that any research on donated tissue will not be performed in any way that identifies me or the donor.

__I authorize and understand **__I do not authorize**

AUTHORIZATION

E. "Restricted health information" from the medical record can be provided to researchers as long as identifying information is removed.
I authorize ACC to release "restricted health information" to the recipient(s) as long as all identifying information is removed (as specified in part D) and as long as the release is for research purposes only. "Restricted health information" includes but is not limited to information related to the type and location of cancer; method of cancer diagnosis; type of symptoms and duration of symptoms; treatments for cancer and other medical conditions; research protocols; developmental disabilities; HIV/AIDS testing; genetic testing; and mental health.

__I authorize and understand **__I do not authorize**

F. There is no financial or direct health benefit to the family.
I authorize ACC to release donated tissue to the recipient(s) and understand that:

-There may be financial benefit to the recipient from scientific advances (including but not limited to bioassays or other biotechnological products, cell lines, cellular or anti-body based therapies, and pharmacologic agents) developed by using or studying the donated tissue.

-There are no plans to provide financial benefit, profit, or compensation to me or any of the donor's family member as a result of participating in tissue donation or from any scientific advances developed from the use or study of the donated tissue.

-There will be no disclosure of research results to me or any of the donor's family members as a result of participation in tissue donation or with the development of any scientific advances developed from the use or study of the donated tissue.

-There will be no other benefit (for example, disease testing, diagnosis or treatment) for me or any of the donor's family member as a result of participation in tissue donation or from the development of any such scientific advances, except as the benefits become available to the general public.

__I authorize and understand **__I do not authorize**

G. The family does not control the tissue once it is provided to a recipient.
I authorize ACC to release donated tissue to the recipient(s) and understand that, upon receipt of the tissue by the recipient, the tissue and all subsequent scientific advances derived from this tissue are property of the recipient to the fullest extent permitted by law. I understand that while ACC is in possession of the tissue and prior to receipt of the tissue by the recipient, I have full right to withdraw

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5. G. (continued)

consent for use of the tissue; and that this withdrawal of consent will result in disposal of tissue as specified in section 4. I understand that withdrawal of consent must be provided to ACC in writing.

__I authorize and understand **__I do not authorize**

Section 6. I acknowledge that

-I have read this four page document
-all blank spaces have been completed
-I understand the content of this form
-I have had the opportunity to ask questions
-all my questions have been answered to my satisfaction.

Signature of Next of Kin/Power of Attorney: ________________________________Date: ________ Time: ______

***Contact telephone number(s):_________________________________

____

Address of Next of Kin/Power of Attorney: ______________________________________

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Witness #1______________________________________Witness#2______________________________________

Section 7.

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_____________________________________ ____

Name and title of person obtaining consent

Name and address where autopsy performed