

**MEDICAL RECORD**

**AUTHORIZATION FOR TISSUE DONATION**

In the event authorization for tissue donation is obtained by letter, telegram, or mechanically recorded telephone call, paragraphs 1 and 2 shall be completed by hospital authorities and the letter, telegram, or memorandum confirming telephone call of authorization attached to this form for permanent file.

NAME AND LOCATION OF HOSPITAL 1.	DATE
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2. You are hereby authorized to remove the following-named tissue from the remains of

\_\_\_\_\_ for donation to the Tissue Bank  
*(Name of deceased)*

of \_\_\_\_\_  
*(Name of hospital)*

\_\_\_\_\_  
*(Specify tissue: e.g., bone, artery, cartilage, skin, fascia, dura, nerve, tendon, etc.)*

Authority is also granted to use the tissue in grafts upon living persons, or to dispose of the tissue in a suitable manner.

Signature of witness \_\_\_\_\_

Signature \_\_\_\_\_  
*(Person authorized to consent)*

Address \_\_\_\_\_

Address \_\_\_\_\_

Authority to consent \_\_\_\_\_

PATIENT'S IDENTIFICATION <i>(For typed or written entries, give: Name—last, first, middle; ID no. (SSN or other); hospital or medical facility)</i>	REGISTER NO.	WARD NO.
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Medical Board