

Consent and Authorization for Autopsy

Name	· -
DOB:	
MRN:	

	IVIIN.
INSTRUCTIONS: To be valid, this document 1) must be con obtaining permission, AND 4) must be signed either by the phone call in which permission was given in order to procee	person granting permission or the witness monitoring the
Attending Physician:	
Hospital Service:	Phone#:
Date/Time of Death:	
l, (printed name)	, the (relationship to the deceased)
of the deceased, the Pathology Department of Cincinnati Children's Hospital deceased. I understand that any diagnostic information gain medical record and will be subject to the laws applicable to	ned from the autopsy will become part of the deceased's
Retention of Organs/Tissues: I authorize the removal, examination, and retention of orgates the pathologists deem proper for diagnostic, education, of the eventual disposition of these materials as the pathologises not extend to the removal or use of any of understand that organs and tissues not needed for diagnoswill be sent to the funeral home or disposed of appropriately	uality improvement and research purposes. I further agree gists or the hospital determine or as required by law. This these materials for transplantation or similar purposes. I tic, education, quality improvement, or research purposes
I understand that I may place limitations on both the extent devices. I understand that any limitations may compromis usefulness of the autopsy for education, quality improvemer to ask any questions that I may have regarding the scope or	e the diagnostic value of the autopsy and may limit the it, or research purposes. I have been given the opportunity
None. Permission is granted for a complete autopsy Permission is granted for an autopsy with the following li By signing below, I confirm to the best of my knowledge	·
deceased's remains.	
Time:	Date:
Signature of person authorizing the autopsy	Printed Name
Time:	Date:
Signature of physician obtaining permission	Printed Name
	Via: ☐ Phone ☐ Video ☐ On-site
Print name of interpreter and ID number (if applicable)	
☐ This section is to be initiated if the caregiver is not p The above statements were read by the person obtaining permission to provided the opportunity to ask questions regarding the scope and purp the permission of the parties and affirms that the person granting permis	the person granting permission. The person granting permission was ose of the autopsy. The undersigned listened to the conversation with sion gave consent to the autopsy as indicated above.
Name of caregiver:	
Telephone number: () Dat Comments:	e: / / Time:
Caller Signature Printed	Name Time/Date
Witness Signature Printed	Name Time/Date



