Icahn School of Medicine at Mount Sinai

The Mount Sinai Medical Center
The Mount Sinai Hospital
Icahn School of Medicine
1 Gustave L. Levy Place
Box 1230
New York, NY 10029-6574

Alzheimer's Disease Research Center
Alzheimer's Disease and Schizophrenia Brain Bank
Information contact:
Jorge Ginory-Perez
718-584-9000, Extension 1704
646-832-7391
Jorge.ginory-perez@mssm.edu

PERMISSION/CONSENT FOR AUTOPSY/BRAIN DONATION

Date: _____ Time: _____

I hereby authorize the Icahn School of Medicine, Department of Psychiatry, Alzheimer's Disease Research Center/Alzheimer's Disease and Schizophrenia Brain Bank to perform an autopsy on the body/brain of my

_____, _____
(Relationship. Please print.) (Name of the deceased: First, middle, last. Please print.)

For DIAGNOSTIC and RESEARCH purposes. I understand that tissues and bodily fluids may be removed and retained for DIAGNOSTIC AND RESEARCH purposes and that all pertinent medical records will be reviewed and duplicated as necessary. I state that by my relationship to the deceased I am by law in control of the remains of the deceased and therefore authorized to consent to autopsy, tissue donation and release of medical records.

_____ _____
(Signature, consenting next of kin) (Name: First, middle, last. Please print.)

_____ _____
(Signature, Witness) (Name: First, middle, last. Please print.)

_____ _____
(Signature, Witness, optional) (Name: First, middle, last. Please print.)

Type of autopsy/tissue donation: Total ___ Exclusions ___ Specify exclusions _____ Brain only ___

Address and telephone number of next of kin giving consent for autopsy:

_____ _____
_____ Telephone number

Body is to be released by: _____, _____
(Time) (Date)