



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

Department of Psychiatry
 (212) 824-7008 Tel
 (212) 860-3945 Fax
**Alzheimer's Disease and Schizophrenia
 Brain Bank**
 (718) 584-9000 Ext. 6082 Tel
 (718) 365-9622 Fax.
 Vahram.haroutunian@mssm.edu e-mail
Address for Correspondence
 Psychiatry Service
 Bronx VA Medical Center
 130 West Kingsbridge Road
 Bronx, NY 10468

PERMISSION/CONSENT FOR AUTOPSY/BRAIN DONATION

Date: _____ Time: _____

I hereby authorize the Mount Sinai School of Medicine, Department of Psychiatry Brain Bank to perform an autopsy on the body/brain of my

_____, Mr./Mrs./Miss.
 (Relationship. Please print.) (Name of 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

(City, State, Zip Code)

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