The Children's Hospital *of* Philadelphia

DP-1373D
Rev. 6/05

NAME SEX M F

MR#

AGE / DATE OF BIRTH

ACCOUNT#

(PATIENT PLATE IMPRINT)

# AUTHORIZATION FOR AUTOPSY

Name of Deceased MR#

I _____, do hereby grant to the authorities of the Children's Hospital of Philadelphia, permission to perform a complete autopsy upon the body of _____, including removal, retention, study and photography of such organs, parts of organs, or tissues as are deemed necessary or desirable by the proper examining physician in order to determine the cause of death or for use in the medical research and teaching. I understand that this authority includes permission for removal of the brain and eyes, unless specifically exempted below, and that these examinations will not preclude viewing of the body. I also understand that The Children's Hospital of Philadelphia may share information about the deceased with other health care providers who were involved in the deceased's care and with outside labs and specialists to assist us in the performance of the autopsy. The nature of the autopsy examination and the condition in which the body will be delivered to the funeral director have been explained to me.

I assume responsibility to provide the services of a funeral director for the purpose of burial.

This authority shall be limited only by the following express conditions:

_____

_____

I certify that I have read and fully understand the above Consent and that all of my questions were answered to my satisfaction.

| | | |
|---|---|---|
| Signature of Consenting Party and Relationship to Patient | Signature of Physician Obtaining Consent | Date/Time |
| Printed Name of Consenting Party | Printed Name of Physician or | Beeper/Contact # |

**IF CONSENTING PARTY IS NOT AVAILABLE TO SIGN THIS FORM:**

| | | |
|---|---|---|
| Consenting Party's Name and Relationship to Patient | Means of Obtaining Oral Consent | Date/Time |
| Signature of Witness to Oral Consent | Signature of Physician Obtaining Oral Consent | |
| Printed Name of Witness to Oral Consent | Printed Name of Physician or | Beeper/Contact # |

AEL 8/2005