CONSENT TO DISPOSAL

I, the undersigned, authorize Rice Memorial Hospital to dispose of the

____________________________________
(Name of Extremity)

____________________________________
(Name of Patient)

in accordance with the hospital policy.

____________________________________
(Signature of Patient)

OR

____________________________________
(Neat of Kin or Guardian)

Witness:

____________________________________
(Witness:)

____________________________________
(2 Witnesses for phone consent)

CONSENT FOR RELEASE OF SPECIMENS

I hereby authorize Rice Memorial Hospital to release

____________________________________
(Specimens / Products of conception)

____________________________________

from ____________________________
(Patient) to the ____________________________
(Specify Agency)

____________________________________
(Patient/Parent/Guardian)

Received from Rice Memorial Hospital, the above listed specimens / products of conception. I understand that this specimen may be a biohazard and direct exposure should be avoided in order to minimize the risk of possible infections, such as HIV and hepatitis. I now assume responsibility of this specimen.

____________________________________
(Signature of Person)

____________________________________
(Title)

____________________________________
(Witness)

____________________________________
(Title)