DT0368

CONSENT TO DISPOSAL

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

_____ of _____
(Name of Extremity) (Name of Patient)

Date _____

Time _____

in accordance with the hospital policy.

_____ Witness: _____
(Signature of Patient)

OR

_____ Witness: _____
(Next of Kin or Guardian) (2 Witnesses for phone consent)

_____

CONSENT FOR RELEASE OF SPECIMENS

I hereby authorize Rice Memorial Hospital to release _____
(Specimens / Products of conception)

_____

Date _____

Time _____ from _____ to the _____
(Patient) (Specify Agency)

_____
(Patient/Parent/Guardian)

Date _____

Time _____

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)