



**THE JOHNS HOPKINS
HOSPITAL**

NAME OF
PATIENT _____

DATE OF
BIRTH _____

CONSENT FOR POST-MORTEM EXAMINATION (AUTOPSY)

The post-mortem examination (autopsy) is a medical procedure that is performed to learn more about the cause of death and the reasons for that death. Many families find this helpful. Each examination also contributes to our medical knowledge and can help other patients who have the same problems.

The examination uses surgical incisions to allow observation and removal of organs. These incisions will not involve the face or any other part of the body that would be visible during viewing. The clothed body will look the same with or without the postmortem examination.

I THEREFORE GIVE PERMISSION TO THE DOCTORS OF THE JOHNS HOPKINS HOSPITAL AND THEIR ASSISTANTS TO PERFORM AN AUTOPSY ON THE DECEASED BODY OF MY

_____, _____
RELATIONSHIP NAME OF PATIENT

I authorize the examination, removal, and retention of organs, tissues, implanted devices, and fluids as the pathologists deem necessary for diagnosis, education, and research. I understand that the remaining organs and tissues will be disposed of appropriately and in accordance with the law.

I understand that I may limit either the extent of the examination or the retention of organs, tissues, or devices. I understand that limitations may decrease the information obtained from the examination. I have been given the opportunity to ask any questions that I may have regarding the scope or purpose of the procedure.

Limitations: **None.** Permission is granted for a complete postmortem examination (autopsy), with examination, removal, and retention of material as the pathologists deem appropriate for the purposes described, and for the disposition of this material.

Permission is granted for a postmortem examination (autopsy) with the following limitations and conditions (please specify):

I ASSUME FULL RESPONSIBILITY FOR BURIAL OR OTHER DISPOSITION OF THE DECEASED.

Signature of person authorizing autopsy

Printed name of person authorizing autopsy

Date

Address of person authorizing autopsy

Telephone number(s) of person authorizing autopsy

Signature of person obtaining/witnessing consent

Printed name and pager of person obtaining/witnessing consent

Printed name and phone/pager of JHH attending physician

Printed names and pagers of other JHH physicians to be notified

Printed names of family or others who should receive report. (Please put addresses on the back of this sheet.)

ADMITTING OFFICE: