



TISSUE DONATION CONSENT

Upon donor's death, or when death is imminent,
please call the following immediately:

Rocky Mountain MS Center Tissue Bank Coordinator
720-626-6060 (on-call phone)

I, _____
(Donors Full Legal Name)

(Address)

(City) (State) (Zip Code)

(Phone)

(Birth Date)

Gender: M/F Race: _____

do hereby express my desire to donate portions of my body,
including my entire brain, spinal cord, optic nerves, pituitary, and
CSF, to The Rocky Mountain Multiple Sclerosis Center Tissue
Bank. I understand and agree that the bank may use these portions

at its discretion for MS research, education, or other scientific purposes. My closest relatives have been informed of my desire and intention in this matter. At my death, or when my medical condition becomes critical, my closest relatives have been told of my desire for them to immediately notify the Rocky Mountain Multiple Sclerosis Center Tissue Bank Coordinator at (720) 626-6060. My survivors assume responsibility for the disposition of my remains except for those portions identified herein.

I understand that all personal information will be removed from the donation and it will be identified with a code. Only the team at University of Colorado will have access to the link between my code and my identifiable information; and this will be kept secure. I am making this gift freely and voluntarily, without obligation of any kind on the part of the recipient organization and there will be no reward or compensation to my family or me. I further understand that this gift may be revoked or amended by: (1) a signed statement by me; (2) an oral statement made by me in the presence of two witnesses; (3) any form of communication during a terminal illness or injury that is address to a physician; or (4) delivery of a signed statement to Rocky Mountain MS Center. I understand that this gift is irrevocable upon my death and that no other consent or concurrence by anyone else is required. I understand and agree that after my death no one can reverse or overturn my desire to donate. I hereby agree that this consent agreement shall be governed by the laws of the State of Colorado. I also authorize the Rocky Mountain Multiple Sclerosis Center Tissue Bank to use, receive, or disclose my coded medical records after my death as appropriate in connection with research. I understand that no identifiable information such as my name or address will be provided to any third party.

(Donor's Signature)

(Print Name)

(Date)

If the donor is unable to sign or is deceased, the legal Next of Kin and a witness must sign.

(Legal Next of Kin Signature)

(Print Name)

(Date)

(Witness Signature)

(Print Name)

(Date)

Legal Next of Kin Information

(Legal Next of Kin – check appropriate box below)

(Address)

(City) (State) (Zip Code)

(Phone)

Legal Next of Kin Relationship to Patient

Numbers indicate legal order of priority

(check appropriate box)

1. Spouse
 2. Adult Child
 3. Parent
 4. Adult Sibling
 5. Grandparent
 6. Aunt/Uncle
 7. Legal Guardian
 8. Other person assuming responsibility for burial