

# Donor Authorization for Anatomical Gift To The Eternal Educational Gift Donation

## 1. Consent

Being 18 years of age or over and of sound mind, I hereby offer my body after death as an unrestricted anatomical gift to the Eternal Educational Gift Donation ("EEGD").

- I understand that my accepted body may be used for the purposes of education in the sound judgment and sole discretion of the EEGD.
- I understand that the acceptance and exact use of me body will be at the discretion of EEGD.
  - Examples of how the gift may be used for education include: medical education and training, forensic sciences (e.g., pathology, engineering, anthropology).
- I understand EEGD reserves the right to preserve and retain individual tissues and organs from my gift for the purposes of education and research.

## 2. Applicable Law and Policies

I understand this donation is subject to applicable law and EEGD policies in effect at the time of my death.

## 3. Duration of Donation (check box)

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Permanent Donation: The EEGD may retain my donation indefinitely to be used in any manner that the EEGD deems necessary and appropriate, externally to the EEGD, without time constraints on the use of my body. Following the use of my body, the EEGD will bury the ashes at [insert burial site here]. With permanent donation, the body or ashes will not be returned.

## 4. Release of Medical Information

I authorize and all health care providers (e.g., hospitals, nursing homes, physician practices) holding my health information at the time of my death to release my health information to the EEGD and funeral facility personnel for the purpose of implementing my donation. Release of my health information may be in verbal and/or written form, including copies of medical records. This authorization extends to the release of information, if any, regarding: alcohol and drug/abuse treatment; psychological and social work counseling; HIV, AIDS or ARC; communicable disease or infections, including sexually transmitted diseases, venereal disease, tuberculosis and hepatitis; and genetic information. The EEGD will follow all applicable law as well as EEGD policies to ensure the confidentiality of my health information, but I understand that once a health care provider or the EEGD discloses my health information to a recipient, neither the health care provider nor the EEGD can guarantee that the recipient will not re-disclose my health information. The EEGD is not liable for the actions of others who may further disclose the information.

## 5. Further Information

This authorization is voluntary and no treatment, payment, or enrollment or eligibility for benefits is conditioned upon my signing of this form. This authorization expires only upon the revocation of my anatomical gift. For information on revoking this authorization and delivering a revocation, please contact the EEGD.

My signature below confirms that I have read the informational guide attached to this Donor Authorization form. I understand any questions that may arise may be directed to the EEGD, by phone at [TBD] or by email at [TBD].

Signatures

DONOR

Name (Please Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

#### WITNESSES

The Donor signed this Authorization for Anatomical Donation, and we, in the Donor's presence and at the Donor's request, have provided our names as witnesses to the Donor's signatures. We state that the Donor appears to be at least 18 years of age and appears to be of sound mind and not under or subject to undue influence.

#### Witness 1

Name (Please Print)\_\_\_\_\_

Signature\_\_\_\_\_

Street Address\_\_\_\_\_

City, State, Zip Code\_\_\_\_\_

Telephone\_\_\_\_\_

#### Witness 2

Name (Please Print)\_\_\_\_\_

Signature\_\_\_\_\_

Street Address\_\_\_\_\_

City, State, Zip Code\_\_\_\_\_

Telephone\_\_\_\_\_