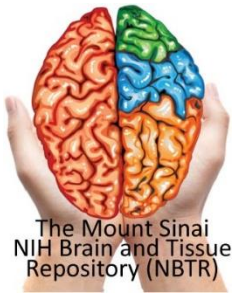

NIH NeuroBioBank
Facilitating Research and Creating Awareness
Brain and Tissue Repository (NBTR)
JJ Peters VA Medical Center
130 West Kingsbridge Road
Room 5F-04D
Bronx, NY 10468
Phone: 718-584-9000 x1848
Fax: 718-741-4746
Email: NBTR@mssm.edu

PERMISSION / CONSENT FOR
BRAIN DONATION Request for Consent of an Anatomical (Brain) Gift

Date:_____ Time:_____

I hereby authorize that a harvesting of brain tissue be performed on the body of my

_____ Mr./Mrs./Miss_____

Relationship (please print) Name of deceased: first, middle, last (please print)

for diagnostic and research purposes. I understand that tissue and bodily fluids may be removed and retained for diagnostic and research purposes, including genetic studies, and shared with qualified researchers. I have no reason to believe that this anatomical gift is contrary to the decedent's religious or moral beliefs.

I also understand that all pertinent medical records will be reviewed and duplicated as necessary. Specifically, Personal Health Information relating to medical, psychological, psychiatric and neurological status; Name; address; telephone number; and details of medical care including: dates associated with medical care, diagnoses, medications and laboratory tests and medical record(s) number will be reviewed and information retained for research purposes. However, NO information that may identify the donor, other than age, will be intentionally revealed to anyone outside of the research team unless required by law.

De-identified data collected from this research will be shared in scientific databases that anyone can use. These databases will be kept indefinitely and researchers around the world will use these for countless future studies. You will not receive any individual results or direct personal benefit from this future research, but it will benefit individuals who suffer from serious diseases and may lead to scientific advances that will benefit society in general. The de-identified results of this research may be shared on public scientific websites, in scientific meetings, and in scientific journals. This authorization means that your family member's genetic information and related data may be shared with other researchers, but this will not include any information that could personally identify you or your family member. It is possible, but unlikely, that your family member's genetic information could be used to identify him/her when combined with information from other sources. We do not anticipate further risks to your privacy by sharing your family member's genetic data with these databanks; however, we cannot predict how genetic information will be used in the future.

Right to Withdraw: Should you change your mind about sharing your family member's tissue and related information for these other studies, you have the right to withdraw this consent at any time. Your decision will not adversely affect your care or your family's care at this institution.

Permission for Brain Donation is Granted:

_____ _____

(Signature, consenting next-of-kin) (Name: first, middle, last - please print)

Next of Kin Contact
Information Address:

_____ Telephone Number:_____

_____ Date of Birth (Donor):_____

_____ Social Security (Donor):_____