UC Davis MIND Institute
Brain Endowment for Autism Research Sciences (BEARS) Program

Director: Cynthia Schumann, Ph.D.
24-Hour Toll Free: (855) 221-HOPE Fax: (916) 703-0483

Consent for Anatomical Gift and Use/Disclosure of Donor's Health Information For Research

Donor's Full Legal Name:_____Gender:_____
(as appears on birth certificate)

Donor's Date of Birth:_____ Donor's Date of Death: _____

Donor's Birthplace:_____ Donor's Time of Death: _____
(as appears on birth certificate)

In the hope and with the expectation that this consent form will contribute to the advancement of medical knowledge and progress, and may otherwise reveal information about autism and related neurodevelopmental disorders, I, _____, authorize the removal of the donor's brain, along with samples of skin and blood to be taken by the UC Davis MIND Institute staff, their designee or contractors. I authorize the MIND Institute to receive, retain, preserve and/or contribute the donor's tissues for scientific research purposes in whichever way the facility deems appropriate. I understand that any part of the collected specimens may be disposed of in accordance with standard practice. I also authorize the use and disclosure by all of the donor's medical providers, the donor's personal health information (including, without limitation, medical records), to the extent provided by California and Federal law, for research purposes at the MIND Institute and for others whom the MIND Institute collaborates with (including, without limitation, researchers around the world, Autism BrainNet and officials who may need the information to assure that the research is done appropriately). I understand that every effort will be made to protect the identity of the donor and myself, and that the donor's name will be removed from medical records and/or tissue prior to distribution to researchers. I understand that once the donor's personal health information is released, it might not be protected by the privacy laws and might be shared with others. Finally, I agree that the MIND Institute or staff of Autism BrainNet may contact me in the future for the purpose of obtaining additional diagnostic information about the donor and for the purpose of completing a standardized diagnostic interview.

I understand that all of the foregoing will be performed without charge to me.

Family/Caregiver: _____ Phone: _____

Relationship to Donor *(including any specific authority to act for the donor):* _____

Address: _____

Signature:_____ Date: _____

Witness: _____ Phone: _____

Witness Signature: _____ Date: _____

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Oral Consent: Staff Signature:_____Date:_____

Signature of a Witness:_____ Date:_____