Form 4

HIPAA AUTHORIZATION
TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

_____ _____
Donor's Name Donor's Date of Birth

Choose one:

- o Antemortem Gift: I have executed an Antemortem Anatomical Gift donating my brain and other selected body specimens to the Boston University [PI lab/research center].
- o Postmortem Gift: I am the spouse, or other next-of-kin, or an individual legally authorized to take custody and make disposition of the body of the deceased individual named above (the Donor) and am authorized to release the Donor's protected health information. I have executed a Postmortem Anatomical Gift donating the Donor's [fill in the blank] to:
  Boston University [PI lab/research center contact information]

In furtherance of this donation:

1. I authorize and request the person making the final arrangements for my/the Donor's body to call the Boston University [PI lab/research center] immediately upon death to determine if a donation will be accepted and, if accepted, to make arrangements for the removal/collection of my/the Donor's brain and other selected body specimens and for their delivery to the Boston University [PI lab/research center], at Boston University's expense. **I understand that my brain and other body specimens must be removed and sent to Boston University [within 24 hours of the time of death?], except in unusual circumstances where an exception can be made by the University.**

2. I authorize any health care provider or other person who holds my/the Donor's health information or other personal information to disclose the information to Boston University for the purpose of carrying out this donation, including for purposes related to the use of my brain and other body specimens. This includes, without limitation all test results, pathology reports, photographs, and autopsy findings.

3. I understand that this authorization will remain in effect until the donation process is complete, or until I provide a written notice of revocation to the Boston University [PI lab/research center] at the address above. If I revoke, the revocation will be effective immediately upon receipt of my written notice. I understand that the revocation will not

have any effect on any action taken in reliance on this instrument before notice of revocation is received by Boston University.

4. This Authorization is voluntary. I understand that my/the donor's treatment by this health care provider does not depend upon my signing this Authorization. If I do not sign it, my/the Donor's records will not be released as directed in this Authorization.

5. I understand the information used or disclosed pursuant to this Authorization may be re-disclosed by a recipient and may no longer be protected by federal privacy regulations.

Name (Printed):	
Signature:	
Date of Signature:	
If not signed by Donor, state relationship:	