I have provided a copy of this consent form to the person(s) identified below and have instructed them to contact the Museum of Human Disease to organise the preservation of my tissue as soon as possible after my death.

	Name	Contact phone number
Next of kin		
Care provider		
Doctor		a.1 (H)-2.9 (um)--12.3 ( )-12.2 (mon)-12hi3 (