BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Release of Human Remains Form

I, _____ _____ request the return of my
(Print Name) (Date of Birth)

_____
(body part, organ or tissue)

removed from me on _____ for:

- ☐ Personal _____
- ☐ Religious _____
- ☐ Other reasons _____

- I agree to use only as indicated above.
- I understand that human remains will break down if kept at room temperature.
- Human remains must be kept in a safe and prepared condition. Burial must be done on your personal property, 18 inches below the ground.
- I understand that body tissue that is not properly prepared may carry disease.
- I release Bronson Healthcare Group and Pathology Services of Kalamazoo, P.C. from any liability that may be associated with the body part.
- I agree to take full responsibility for proper handling of these human remains.

Patient Signature: _____ Date: _____ Time: _____

I have interpreted this form to the patient, a parent, closest relative or legal guardian.

Voice/Video Service: _____ Interpreter ID#: _____ Date: _____ Time: _____

Interpreter's name (print): _____ Agency: _____

Interpreter's Signature: _____ Date: _____ Time: _____
Interpreter (if applicable)

Witness: _____

- ☐ I have verified negative HIV, Hepatitis B, and Hepatitis C. (order HIV, HBSG (hepatitis B surface antigen), HCVB)

  Date of testing: _____ (results must be obtained during current pregnancy)

  For Release of Fetus and/or Products of Conception including Placenta, see guidelines in the online OB manual.

NOTE: This body part must be released in a leak proof, puncture-proof container. Container must be labeled "Medical Waste Special Use". Label with appropriate Biohazard labels.

*Complete Form: **Signed Original** to Chart **One Copy** to patient*