PKD FOUNDATION
Polycystic Kidney Disease

I, _____, wish to make an anatomical gift of residual tissue from elective surgery for use in medical research. I authorize my physician and medical facility to release tissue of no clinical value secondary to the surgical procedure and to ship the tissue to a research institution. I consent to have my physician and hospital staff involved in the case provide the necessary information to the PKD Foundation in order to make arrangements for the donated tissue to be transported to the research facility. I understand that no personal identifiers will be provided to the investigator and I will not be contacted by the research facility. The investigator will be provided non-identifying information such as my gender and age, date of surgery, surgeon's name and laboratory test results. Please return via email for fax (816.268.8478).

Procedure: _____

Date of surgery: _____

Physician(s): _____

I give permission for donation of the following tissues: _____

_____

_____
Signature

_____
Print name

_____
Hospital Name and Address

_____
Home Mailing Address

_____ _____
Witness Signature Witness Signature

_____ _____
Witness Print Witness Print