



Institute for Plastination

MEDICAL HISTORY RELEASE AUTHORIZATION FORM

(Return this form with 'Donor consent form')

Please Print

Name

Last:

First:

Middle:

Gender Male Female

Height

Weight

Primary Occupation (prior to retirement):

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Disease History (example childhood diseases, heart, kidney, etc.):

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MEDICAL HISTORY RELEASE AUTHORIZATION FORM (CONT.)

Operation and Accident History:

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Disabilities or Deformities:

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I authorize the Institute for Plastination to receive access to my full medical records.

Yes No

I authorize my medical history to be made public along with the plastinated specimen(s) made from my body.

Yes No

Print name: Date:

Signature: