CONSENT/AUTHORIZATION FORM

I authorize St. Joseph's Women's Hospital to preserve for scientific research and/or teaching purposes or to dispose of my placenta consistent with facility policy and state and federal regulations. I further authorize St. Joseph's Women's Hospital to provide the removed placenta to private companies for research or commercialization purposes. _____

I acknowledge that if the placenta is provided to a private company, all information linking me to the donation will be de-identified in accordance with state and federal regulations (including, but not limited to, HIPAA), and that any company using the placenta for research will have no way to connect the donated placenta to me. _____

If research is performed it may or may not result in discoveries that are beneficial to others or profitable to the companies conducting the research. By executing this document, I am forfeiting all rights to any claims to future profits gained from research, and claim to any intellectual property derived from the research or any other matter related to the donation of my placenta. _____

I acknowledge that I have the right to refuse authorization without jeopardizing my medical care and the medical care of my unborn child, and we will continue to receive the same medical treatment regardless of my decision. _____

I have read and understand this Consent and know that I can refuse to donate my placenta without prejudice. I am signing below prior to the collection of my placenta. I understand that my decision to collect my placenta is voluntary. I understand that by my signature below I am verifying that I have been given an opportunity to and have read all of the information in this Consent. I recognize that before signing this Consent I had the opportunity to call St. Joseph's Comprehensive Research Institute at (813) 870-4760 to ask questions regarding the processing of the placenta, and to make arrangements with them to receive my placenta on the day of my Cesarean Section. I also recognize that before signing this Consent I should consult with my obstetrician and/or attending physician regarding questions concerning the collection of my placenta during delivery, including clarification of medical terms, and that St. Joseph's Women's Hospital is not my physician.

☐ I want my placenta collected.

_____ _____ _____
(Mother's Printed Name) (Mother's Signature (Date)

☐ I do not want my placenta collected.

_____ _____ _____
(Mother's Printed Name) (Mother's Signature) (Date)

_____
(Witness Signature)