BIOCETT
Bio Cell and Tissue Technologies, Inc.

TISSUE RELEASE FORM

RELEASE INFORMATION:

1. Date of Tissue Storage: _____/_____/_____

2. BIOCETT ID Number: _____

3. Patient (donor) Name: _____

4. Medical Record Number: _____

5. Type of Tissue(s): _____

6. Authorization (Check):

☐ I authorize the release of the tissue to be discarded by BIOCETT.

☐ I authorize the release of the tissue to _____.

☐ I do not authorize the release or discard of the tissue, and request an additional three months of storage.

Reason for additional storage: _____

_____

_____

Return this Form to:

BIOCETT
PO Box 900103
Sandy, Utah 84090

Fax to: 801-569-3174

Email: jpierce@biocett.com

_____
Physician Signature or Designee

_____
Typewritten/Printed Full Name of Physician

_____
Address

_____
City State Zip

_____
Telephone Date