

# NIH RECOVER: A Multi-site Pathology Study of Post-Acute Sequelae of SARS-CoV-2 Infection

## Autopsy Consent Form

### A. Patient Information

|                                         |                         |
|-----------------------------------------|-------------------------|
| Name of Decedent                        | Date of Birth:          |
| Name of Hospital/Institution:           | Date and Time of Death: |
| Institution Contact Name and Telephone: |                         |

### B. Attestations

1. I have received the "Autopsy Information Sheet" and I understand that I have the right to arrange for the autopsy to be performed elsewhere but prefer to have it performed as part of the RECOVER Initiative's research study.
2. I agree to the removal, examination, and retention of organs, tissues, prosthetic devices, and fluids that the pathologists deem proper for diagnostic, educational, quality improvement, and research purposes.
3. I understand that this consent does not extend to the removal or use of any of these materials for transplantation or similar purposes, which requires a separate permission.
4. I understand that organs and tissues needed for the research study will be de-identified and sent to a biorepository for processing and storage.
5. I understand that organs and tissues not needed for diagnostic, educational, quality improvement, or research purposes will be sent to the funeral home with the decedent.
6. I understand that I may place some limitations on both the retention of organs and the extent of the autopsy. I understand that any limitations may compromise the diagnostic value of the autopsy or may limit the usefulness of the autopsy for education, quality improvement, or research purposes.
7. I agree to the eventual disposition of retained materials as determined by the pathologists or the standards of the institution.
8. I understand that any diagnostic information gained from the autopsy will become part of the deceased hospital medical record.

9. I understand that protected health information from the decedent's electronic medical record will be stored in a national database for the life of the study.
10. I understand that the clinical autopsy report includes protected health information and as a result, the same rules of privacy and confidentiality that apply to medical records of living patients also apply to autopsy examinations and reports.
11. Because I am authorized by law to consent to the autopsy on behalf of the deceased, I understand that I have the right to have a copy of the clinical autopsy report (preliminary and/or final) sent to me, and that it is preferable to review the findings with a clinician.
12. I understand that I will be asked whether I want the clinical autopsy report sent to me when I sign the consent for the clinical autopsy procedure. I understand that I will not receive research results.
13. I also understand that genetic or examination findings from the RECOVER study may result from future research using my relative's de-identified specimens, but those results will not be shared with me. However, I understand that study outcomes may help others in the future.
14. I understand that protected health information may be shared with authorized individuals as part of the RECOVER research study.
15. I have been given the opportunity to ask any questions that I may have regarding the scope or purpose of the autopsy and I have been provided the RECOVER autopsy Information Sheet for families.

### C. Consent

|                                                                                         |                           |
|-----------------------------------------------------------------------------------------|---------------------------|
| Name:                                                                                   | Relationship to deceased: |
| Signature                                                                               | Date:                     |
| <input type="checkbox"/> Full autopsy                                                   |                           |
| <input type="checkbox"/> Limited autopsy (describe)                                     |                           |
| <input type="checkbox"/> Organ retention (select if NOK wishes to have organs returned) |                           |

**Consenter and Witness Signatures** (the consenter and witness must be present for the entire consent process, and both must confirm voluntary consent of next of kin)

|                               |                    |
|-------------------------------|--------------------|
| Clinical personnel name:      | Witness name:      |
| Clinical personnel signature: | Witness signature: |
| Date:                         | Date:              |

**Consent by telephone** (the witness must independently ask and confirm the consent)

|                               |                   |
|-------------------------------|-------------------|
| Clinical personnel name:      | Witness name:     |
| Clinical personnel signature: | Witness signature |
| Date:                         | Date:             |