When you sign this form, you are agreeing to take part in this leiomyosarcoma paraffin tissue block collection and research study. This means that you have read this consent form, your questions have been answered, and you have decided to volunteer. Your signature also means that you are permitting Stanford University Medical Center to use your personal health information collected about you for research purposes.

This signed consent form will be kept on file – please keep a copy for your own records. Since this is a confidential tissue bank, your tissue block will be given a number and researchers will not have access to your identifiable information.

PLEASE SIGN &
RETURN ONLY THE NEXT PAGE TO:

Sharon Anderson MSW
Tissue Coordinator
850 Pointe Pacific Dr. #5
Daly City, CA 94014

Tel. 650-922-8762
Email: 2SharonAnderson@gmail.com

Leiomyosarcoma Paraffin Tissue Block Repository
Donor Signed Request for PB Transfer

1. I agree to participate in this study, meaning that my tissue block may be requested and subsequently stored in the tissue bank.

2. I agree that my tissue block may be used for research purposes (the goal of the tissue bank), in an anonymous and confidential way. Decisions on research to be performed are provided by a scientific advisory committee, according to NIH Guidelines.

Please check below on whether you may be contacted:

____ YES, I may be contacted by the tissue bank coordinator only (not by any researchers) if there is any question about my sample.

____ NO, please do not contact me.

Hospital where surgery was performed – (needed to attain tissue blocks on your behalf)

Hospital Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Date of Surgery: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Relative contact in case we cannot reach you at the above

Name: _____ Phone: _____

Name of Subject (Please Print) **(Subject is patient with LMS)**	**Signature of Subject** **(If patient cannot sign for self – use box below)**	**Date**

For Use With Authorized Representative Signature

Authorized subject's Representative (Please Print)	**Authorized subject's Representative (Signature)**	**Date**

Provide a brief description of above person's authority to serve as the subject's authorized representative, (i.e. relative, spouse, guardian, etc.)