

# CONSENT FOR TRANSFER OF A CLINICAL DNA SPECIMEN

Use this form if you have had clinical DNA testing at PreventionGenetics and wish to have the remaining sample transferred to our DNA Bank.

PLEASE PRINT LEGIBLY.

## PATIENT INFORMATION

FIRST NAME \_\_\_\_\_ MIDDLE NAME(S) OR INITIAL \_\_\_\_\_

LAST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

PATIENT'S PREVENTIONGENETICS ACCESSION NUMBER \_\_\_\_\_

*Deposit Identification Number can be found on the signature page of the Banking Agreement*

NAME OF PERSON COMPLETING THIS FORM (if other than patient) \_\_\_\_\_

I AM A REPRESENTATIVE OF THE DEPOSITOR  Yes  No

I AM PARENT, GUARDIAN, OR AGENT WITH POWER OF ATTORNEY FOR DEPOSITOR  Yes  No

## DNA TRANSFER

Amount of DNA to be transferred: **ENTIRE REMAINING SPECIMEN**

Please send sample to:

**PreventionGenetics DNA Bank** \_\_\_\_\_

Method of Shipment: **N/A**  
i.e. FedEx, UPS, DHL

**3800 S. Business Park Ave** \_\_\_\_\_

Account # to Chage: **N/A** \_\_\_\_\_

**Marshfield, WI 54449** \_\_\_\_\_

## SIGNATURE

My signature authorizes the transfer of the Clinical DNA specimen to the Prevention Genetics DNA bank.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

Fax or mail this completed form to:

**PreventionGenetics LLC - DNA Banking**

ATTN: Donna Dorshorst

3800 S. Business Park Ave, Marshfield, WI 54449

Phone: 715-387-0484 Fax: 715-384-3661

Email: DNABanking@PreventionGenetics.com