



CONSENT FOR TRANSFER OF A DNA SAMPLE
Patient Authorization

I give my consent for the withdrawal and transfer of a portion of the patient's DNA sample.

Patient's Name: _____

Patient's Date of Birth (month/day/year): _____

Patient's Medical Record Number or PreventionGenetics ID Number (PGID) if available: _____

Person Completing This Form: _____

Relationship to Patient: _____

Amount of DNA to be transferred: _____
Please send the sample to (name/address):
Method of Shipment: (i.e. Fedex or UPS)
Account # to Charge:

Your signature (patient signature) on this document indicates that you authorize the shipment of a portion of a Clinical DNA sample to the name/address listed above. Once the DNA is shipped, PreventionGenetics is absolved of all responsibility for this material.

Patient's Signature Date

If you are NOT the patient but are signing on behalf of the patient, complete the following:
I, (print full name) _____, confirm that I am the legally appointed representative for the patient, and I have CIRCLED my relationship to the patient below*:
List of relationships: Parent with Parental Rights, Registered Kinship Care Relative, Court Appointed Guardian, Legally Appointed Healthcare Agent, Medical Power of Attorney, Power of Attorney with Right to See Medical Records, Surrogate Decision Maker, Court Appointed Personal Representative of Deceased

Signature Date

*If other than parent, you must attach proof of your authority to act on behalf of the patient.

Please fax or mail the completed form to: