CONSENT FOR TRANSFER OF A DNA SAMPLE

Healthcare Provider 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 (originally ordering healthcare provider) 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.

_____ _____
Signature Date

Please fax or mail the completed form to:

3800 South Business Park Avenue · Marshfield, WI 54449
Ph: 715.387.0484 · Fax: 715.384.3661
www.preventiongenetics.com