Section of Cytogenetics
PFI: 3492-7093A610
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The Rockefeller University Hospital
1230 York Avenue
New York, NY 10065

AUTHORIZATION FOR SECTION OF CYTOGENETICS
THE ROCKEFELLER UNIVERSITY HOSPITAL
TO RELEASE CLINICAL LABORATORY REPORTS

I hearby authorize the above laboratory to release any results from FA testing done as part of the cytogenetics clinical laboratory to:

Physician/Genetic Counselors Name: _____
Physician/Genetic Counselor Phone Number: _____

Participant Tested: _____ (names)

If participant is a minor:
Parental Signature: _____ Date: _____

If participant tested is a consenting adult:
Signature: _____ Date: _____

If participant tested in an adult not legally capable of giving consent:
Guardian Signature: _____ Date: _____

If you have any questions or concerns about this form please contact our genetic counselor Erica Sanborn at 212-327-8613 or Dr. Arleen Auerbach at 212-327-7533.

Arleen D. Auerbach, PhD
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