



**LABORATORY OF GENOME MAINTENANCE  
THE ROCKEFELLER UNIVERSITY HOSPITAL  
TO RELEASE RESEARCH FINDINGS**

I understand that I am donating a biological sample for research purposes. Some of the testing that may be done on this sample is genetic testing that might have implications for me or my family. I understand that by law, any results that come from this research testing must first be confirmed in a clinical laboratory before a clinician can review the results with me. If results are obtained through this research, the Rockefeller University may share them with the following physician/genetic counselor/clinical laboratory so that the results can be confirmed by a clinical laboratory:

Physician/Genetic Counselor Name: \_\_\_\_\_

Physician/Genetic Counselor Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Also, I understand that my/my child's results will be shared with a clinical laboratory of my doctor's choosing based on test availability, insurance, and other clinical factors.

**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 Study Coordinator at:  
fanconiregistry@rockefeller.edu (212-327-8612).*

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