Section of Cytogenetics
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New York, NY 10065

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

I hereby 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 is an adult not legally capable of giving consent:
Guardian Signature: _____ Date: _____

If you have any questions or concerns about this form please contact us at fanconiregistry@rockefeller.edu (212-327-8612) or contact Dr. Arleen Auerbach at auerbac@rockeller.edu (212-327-7533).

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