



Section of Cytogenetics  
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**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 in 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@rockefeller.edu (212-327-7533).*

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