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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