LAB OF GENOME MAINTENANCE
THE ROCKEFELLER UNIVERSITY HOSPITAL
AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Your patient,_____, is a participant in our International Fanconi Anemia Registry (IFAR). As part of his/her participation, we collect past records and annual records going forward about his/her health. The signature below indicates that the participant, or his/her parent/legal guardian, have given permission for these records to be released to us. Please send chart notes and test results to us at the following address/fax that would be greatly appreciated:

Agata Smogorzewska
Rockefeller University
1230 York Avenue, Box 182
New York, NY 10065
Or fax to 212-327-8262

Physician Name: _____
Physician Phone Number: _____

By signing below, I give permission for the above-named physician, to release any medical records from me/my child and give permission for the study coordinator and Dr. Smogorzewska to obtain future annual records for purposes of the International Fanconi Anemia Registry. I understand that I can withdraw this permission at any time by contacting:

Our study coordinator at fanconiregistry@rockefeller.edu (212-327-8613) or Dr. Smogorzewska at asmogorzewska@rockefeller.edu (212-327-7850).

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: _____

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