LABORATORY OF GENOME MAINTENANCE
THE ROCKEFELLER UNIVERSITY HOSPITAL
TO OBTAIN MEDICAL RECORDS

Your patient, _____, is a participant in our International Fanconi Anemia Registry (IFAR). As part of his/her participation, we try to collect annual records about his/her medical 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. If you could please send any chart notes or medical records from the last year 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 over the last year. I understand that this form will be sent to my doctor annually for records to be obtained for purposes of the International Fanconi Anemia Registry. You can withdraw this permission at any time by contacting:

Dr. Smogorzewska at 212-327-7850 or asmogorzewska@mail.rockefeller.edu
Jennifer Kennedy at 212-327-8612 or jkennedy@rockefeller.edu

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: _____

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