Perelman School of Medicine
University of Pennsylvania

Department of Genetics

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize The Genetic Diagnostic Laboratory at the University of Pennsylvania to disclose the following genetic test result:

Genetic Test Name (Gene): _____

Name of Patient: _____

Date of Birth: _____

Please send the test result to the following location:

Name: _____

Fax number: _____

Mailing Address (if applicable):

_____

_____

_____

This authorization is valid for one year from the date signed, unless I revoke this authorization. The faculty and staff of the Genetic Diagnostic Laboratory must maintain strict patient confidentiality in accordance with state and federal law. The University of Pennsylvania has procedures in place to support this policy. These procedures make it very unlikely that this health information will be improperly disclosed.

I authorize release of the above named record(s):

_____ _____
Signature Date signed

_____ _____
Printed name Relationship to patient

This release form can be faxed (215-573-5940) or emailed (gdllab@pennmedicine.upenn.edu)

560 Clinical Research Building, 415 Curie Boulevard, Philadelphia, PA 19104-6145
Tel: 215-573-9161 / Fax: 215-573-5940 / Email: gdllab@pennmedicine.upenn.edu / Web: www.med.upenn.edu/genetics/gdl

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Please note: There is a $20 fee associated with records that are retrieved from archives.
Contact the laboratory if you are unsure whether this fee would be required for the retrieval of the record.

PAYMENT OPTIONS

☐ I have enclosed a check payable to the "Genetic Diagnostic Laboratory" for $ 20.00

☐ Please charge my credit card for the amount of $ 20.00

☐ VISA ☐ Master Card ☐ Discover ☐ American Express

Card Number: _____ Exp date: _____

Name of cardholder as it appears on card: _____

***Payment information can be mailed or faxed to*:**

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