Perelman School of Medicine
University of Pennsylvania

Genetic Diagnostic Laboratory
Department of Genetics

AUTHORIZATION FOR RELEASE OF DNA SAMPLE

I authorize The Genetic Diagnostic Laboratory at the University of Pennsylvania to release the

DNA sample for _____.
[Printed Name and Date of Birth]

To: _____

_____

_____

_____

Shipping Company to use and Account number: _____

Reason and Specimen Requirements (i.e. amount of DNA): _____

_____

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 DNA sample from the above named individual:

_____ _____
Signature Date signed

_____ _____
Printed name Relationship to patient

The completed version of this form can be faxed (215-573-5940) or emailed (gdllab@pennmedicine.upenn.edu).

Internal Use Only

Date: _____ **Time:** am / pm **Completed by GDL Staff:** _____ Initials

Mode: FedEx UPS USPS Courier: _____ Initials

Comments: