CompGene

ComprehensiveGeneticServices℠

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Clinical Cytogeneticist

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I, parent of _____ _____, hereby authorize
Name of Patient **Date of birth**
Comprehensive Genetic Services (CompGene) to disclose my child's medical records to:

_____
Name/address of physician/medical center disclosing information

Type of information requested: _____

_____

Approximate dates of service: _____

I understand that this consent may be canceled at any time in writing, and in all cases expires in one year, except to the extent that the information was released, as authorized, prior to the notice of cancellation.

_____ _____
Witness Name of Parent/Guardian

_____ _____
Date Parent signature

_____
Address/Phone number of Patient