Christine R. Bryke, M.D.
Clinical Geneticist
Clinical Cytogeneticist

Anthony T. Garber, Ph.D.
Clinical Molecular Geneticist

Jamie Israel, M.S.
Genetic Counselor

I, ______________________________ __________, hereby authorize
Name of Patient **Date of birth**
Comprehensive Genetic Services (CompGene) to disclose my 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 Patient
______________________	______________________
Date	Patient signature

____
Address/Phone number of Patient

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