UW Medicine

CENTER FOR PRECISION DIAGNOSTICS

CONSENT FOR TRANSFER OF A SAMPLE

Healthcare Provider Authorization

I give my consent for the withdrawal and transfer of a portion of the patient's blood or DNA sample.

Patient's Name: _____

Patient's Date of Birth (month/day/year): _____

Patient's Medical Record Number (MRN) if available: _____

Person Completing This Form: _____

Relationship to Patient: _____

Amount of sample to be transferred: _____

Please send the sample to (name/address):

_____

_____

_____

_____

Method of Shipment: _____
(i.e. Fedex or UPS)

Account # to Charge: _____

Your signature (originally ordering healthcare provider) on this document indicates that you authorize the shipment of a portion of a clinical Blood or DNA sample to the name/address listed above. Once the sample is shipped, CPDx is absolved of all responsibility for this material.

_____ _____

Signature Date

Please fax or mail the completed form to:
UW Center for Precision Diagnostics
Room H-561 Health Science Bldg.
1959 NE Pacific Street, University of Washington
Seattle, WA 98195-7655
(Fax 206-616-1899)