Specimen Release Consent Form

Patient authorization for testing to be performed at Foundation Medicine

We have been asked by your treating physician to obtain block(s) and/or slides containing tissue from your biopsy, pathology reports and/or medical records to perform Foundation Medicine testing. These materials and information are to be provided and disclosed to Foundation Medicine for the purpose of clinical testing of your tumor. In order for us to complete this request, we need your authorization for these materials to be released. **Please be aware that performing the requested test(s) may exhaust the tissue that is sent to Foundation Medicine and that if this is the only remaining tissue from your biopsy, additional tests/studies requiring tissue from this biopsy may not be possible in the future.** Upon completion, fax this form to +1 (617) 418-2290 or email to client.services@foundationmedicine.com.

Patient Information

Last Name _____ First Name _____ MI _____

Date of Birth (MM/DD/YYYY) _____ Foundation Medicine Case Number _____

I hereby give authorization for _____ (pathology lab) to release my tissue block(s) and/or slide(s) and disclose information from my health records.

Patient Name *(Print)* _____

Patient Signature _____ **Date** (MM/DD/YYYY) _____

EMAIL TO:

Email: client.services@foundationmedicine.com

FAX TO:

Fax: +1 (617) 418-2290

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