FOUNDATIONONE™ | MEDICINE®

Patient Authorization / Consent Form

PATIENT AUTHORIZATION FOR TESTING TO BE PERFORMED AT FOUNDATION MEDICINE

We have been asked by your oncologist to obtain block(s) and/or unstained slides containing tissue from your biopsy, pathology reports and/or medical records to perform the FoundationOne test. These materials and information are to be provided and disclosed to Foundation Medicine for the purpose of clinical testing. 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.

PATIENT INFORMATION

Name
Date of Birth
Foundation Medicine Reference Number

I HEREBY GIVE AUTHORIZATION FOR _____ TO RELEASE MY TISSUE BLOCK(S) AND/OR SLIDE(S) AND DISCLOSE INFORMATION FROM MY HEALTH RECORDS.

Patient Name OR Personal Representative (Print)	Signature	Date

Foundation Medicine, Inc / 150 Second Street, 1st Floor / Cambridge, Ma 02141 / Tel: +1.888.988.3639 / www.foundationmedicine.com / Fax +1.617.418.2290