FOUNDATIONONE™ | FOUNDATION MEDICINE®

PATIENT AUTHORIZATION /CONSENT FORM

I hereby authorize ____
to disclose the following information from the health records of:

PATIENT INFORMATION		
Last Name	First Name	MI
Date of Birth		
Foundation Medicine Account Number		

INFORMATION TO BE DISCLOSED			
	Slides		Blocks
	Reports		Medical Records
Other:			

______________________	______________________	__________
Patient Name (Print)	Patient Name (Signature) OR	Date
______________________	______________________	__________
Personal Representative	(Relationship to Patient)	Date

This information is to be disclosed to Foundation Medicine for the purpose of clinical testing.

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