PATIENT AUTHORIZATION FOR GENETIC SAMPLE, RESEARCH, AND HEALTH INFORMATION EXCHANGE PREFERENCES

Please complete all fields in this form and return to us via fax: Fax 201-421-2010 or via secure E-mail: **support@genedx.com**.

Requests are processed within 14 days of receipt of this form. Requests cannot be processed if a sample has not yet been received by the laboratory.

PATIENT INFORMATION			
Name		**Date of Birth**	
Address		**Phone Number**	○ Cell ○ Home ○ Work
Name of Ordering Healthcare Provider		**GeneDx Accession Number** (if known)	
Sample Type	○ Blood ○ Buccal Swab ○ Tissue ○ DNA ○ Other: _____		

ONLY COMPLETED BY PATIENT OR AUTHORIZED LEGAL REPRESENTATIVE

By my signature below, I acknowledge that I am authorized to make the below request(s) and I (select all that apply)

☐ Authorize GeneDx to discard and destroy the above individual's biological sample(s) for the accession(s) listed above; if no accession number is provided, then all biological sample(s) submitted to date for the above individual will be discarded. Please note that blood and buccal specimens are typically discarded within eight weeks of collection; only extracted DNA is retained for longer periods.

☐ Request that GeneDx does not share the above individual's deidentified molecular data with collaborators or research partners. This preference will be applied to any existing or future data generated at GeneDx to the best of our ability; however, once data has been de-identified and shared, it may not be possible to retrieve or restrict further sharing.

☐ Request that GeneDx update the above individual's preference for sharing information with health information exchanges (HIEs) which support electronic information sharing among members for treatment, payment and health care operations purposes. Please specify an option below:

- ○ Update preference to OPT OUT of sharing the above individual's data with health information exchanges
- ○ Update preference to OPT IN to sharing the above individual's data with health information exchanges

☐ Request that GeneDx does not contact the individual above regarding research studies

Patient's Name (print clearly): _____

Relationship to Patient: ○ Self ○ Parent/Guardian ○ Other: _____

Patient's Signature/Parent or Guardian's Signature: _____ Date: _____

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