Genetic Testing Data Sheet/Release Form

Patient Name: ____ Date of birth: ___________________

Partner Information:

Spouse/Partner Name:_____________________________ Date of Birth:___________ SS#: ________________

Home Address: ____

Home Phone #: __________________ Cell Phone #: _________________ Work Phone #:__________________

Insurance Company: ____

Subscriber Name: ____________________________________ SS#: __________________________________

ID #: _____________________________________ Group #:____

I authorize the release of all medical information and genetic testing results to my partner/spouse.
I understand that Associates In Women's Health cannot order nor be responsible for my spouse/partner's tests without this release.

____ ________________________

Patient's Signature Date

____ ________________________

Partner/Spouse Signature Date

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