Hunterdon Health
Hunterdon Regional Cancer Center

FAMILY RISK ASSESSMENT PROGRAM – RELEASE OF RECORDS TO PHYSICIANS

NAME: ____ **DOB:** ______________________

We would like to share our findings (including genetic test results, if applicable) and recommendations with your healthcare provider(s). Please provide the name, address, telephone, and fax numbers of any of your healthcare providers with whom you would like us to share this information. Your signature below indicates your request and permission for us to inform your healthcare provider(s) in writing of our recommendations for you based on risk assessment. Typically, we will send this information to your physician(s) *after* we have reviewed it with you in person.

In the event that something prevents you from returning to review this information, we will still forward it to the physicians noted below.

Physician: ____

Address: ____ Phone: ______________________

____ Fax: ______________________

Physician: ____

Address: ____ Phone: ______________________

____ Fax: ______________________

Physician: ____

Address: ____ Phone: ______________________

____ Fax: ______________________

____ ______________________

Signature of Participant Date

OR

_________ Please do not provide written documentation of my genetic test results and/or outcome of my risk assessment to any healthcare provider at this time. I have been told that I will still be provided with copies of my own records. In addition, I have been made aware that I may update this release form at any time.

____ ______________________

Signature of Participant Date