Date: _____

To Whom It May Concern:

_____ _____
(Print Full Legal Name of Patient) (Date of Birth)
has had genetic testing performed by Myriad Genetic Laboratories, Inc. I hereby request that Myriad Genetic Laboratories, Inc. send any of this individual's remaining DNA sample in Myriad's possession to:

_____
(Print Name of DNA Bank, Individual, etc.)

_____
(Print Street Address and Suite Number)

_____
(Print City, State, Zip Code and Country, if applicable)

Signed: _____
(Patient or Patient's Personal Representative Signature)

_____ _____
(Print Street Address and Suite Number) (Telephone Number)

_____
(Print City, State, Zip Code and Country, if applicable)

OR

Signed: _____ Lic. # _____
(Healthcare Professional Signature)

_____ _____
(Print Street Address and Suite Number) (Telephone Number)

_____
(Print City, State, Zip Code and Country, if applicable)

If the patient is unable to sign, the Healthcare Professional who ordered the genetic testing for this patient or the patient's personal representative may sign this form. The Healthcare Professional's signature verifies that he/she has the patient's consent to make this request.

Note: No DNA samples will be released without a signature from either the patient, the patient's personal representative or the patient's Healthcare Professional. Myriad Genetic Laboratories, Inc. will NOT be responsible for forwarding payment to a DNA banking facility.

See attached Return Sample Payment form for the cost of shipping and handling.

Returned Sample Payment Form

Patient Name: _____ Date: _____

Payment Method ($50 shipping and handling fee)

- ❑ Credit Card
- ❑ Personal Check or Money Order to: Myriad Genetic Laboratories, Inc.

I authorize Myriad Genetic Laboratories, Inc. to bill my:

- ☐ MasterCard
- ☐ Visa
- ☐ American Express
- ☐ Discover

Credit Card Number: _____

Exp. Date: _____

Amount: $_____

Signature: _____

Note: Myriad Genetic Laboratories, Inc. will <u>NOT</u> be responsible for forwarding payment to a DNA banking facility.