St George's University of London

St George's Healthcare NHS Trust

S.W. Thames Regional Genetics Service

Please complete as many details as possible and return this form to:

Medical Genetics Unit
St George's University of London
Jenner Wing
Cranmer Terrace
London
SW17 0RE

Fax: 020 8725 3444
Web: www.southwestthamesgenetics.nhs.uk

Our reference: **GEN**

If you have any questions about this form please contact:

(Staff member):

Phone: 02087255333

Email:

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION / RECORDS AND/OR TISSUE SAMPLES FROM YOURSELF

I, ____ give permission for all of the above to be made available to healthcare staff at the South West Thames Regional Genetics Service at St. George's Hospital to assist them in advising other members of my family. I also grant permission for further medical details to be obtained from the Cancer Registry, if required.

My date of birth: My address ____

Address at time of treatment (*if different from above*): ……………………………………………………………

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Approximate date of treatment / surgery (*if applicable & known*): ………………………………………………….

Hospital(s) where treated (*including address(es) if known*): … ……………………………………………………..

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Name of treating Doctor(s) (*if known*):____

Any other relevant information:

Signature…………………………… Print name ……………..………………….. Date …………………..……