ROSETTAGX™
Revealing Genomic Answers

Authorization to Release Biopsy Material to Rosetta Genomics for Molecular Testing

I, (full name) _____, Date of Birth, _____ hereby authorize the Pathology Department at (facility name) _____, to release my biopsy material that was taken on (date of collection)_____ to Rosetta Genomics Inc. in Philadelphia, PA for molecular testing.

I, (full name) _____, having the legal right to do so, hereby authorize the Pathology Department at (facility name) _____, to release the biopsy material of (full name)_____ ,Date of Birth:_____ that was taken on (date of collection)_____ to Rosetta Genomics Inc. in Philadelphia, PA for molecular testing.

Signature of patient or patient's authorized representative: _____

Date: _____

After completion, please fax this form to Rosetta Genomics Inc.,
Fax: 215-382-0815 or mail to address below

Should you have any questions please contact us at: 888-522-7971

Rosetta Genomics Inc
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Philadelphia, PA 19104