FOUNDATIONONE™ | FOUNDATION MEDICINE®

PATIENT AUTHORIZATION /CONSENT FORM

PATIENT IDENTIFICATION INFORMATION		
Last Name:	**First Name:**	**MI:**
Date of Birth:	**SSN:**	

By completing and signing this form, I represent and agree to the following:

- I understand that the Health Insurance Portability and Accountability Act of 1996 provides me with certain rights to the privacy of my protected health information ("**PHI**") and restricts the use and disclosure of my PHI without my authorization.
- I certify that I am the individual identified under "Patient Identification Information" above (or such individual's authorized representative), and that I have authorized my treating physician, Dr. _____ (my "**Treating Physician"**), to (i) order FoundationOne® or FoundationOne Heme clinical testing of my tumor tissue (collectively, the "**Test**"), and (ii) transfer to Foundation Medicine, Inc. (the "**Authorized Recipient**") my tumor tissue sample(s) and any medical records and information required for the Authorized Recipient's performance of the Test.
- I hereby authorize _____ (the "**Pathology Lab**") to transfer to the Authorized Recipient (i) my tumor tissue sample(s) (whether in formalin-fixed paraffin-embedded ("**FFPE**") slide or block form), and (ii) any medical records (including pathology reports) and other health information identified in the order from my Treating Physician (the "**Order**"), including any of my PHI contained in such records and/or information. I further authorize the depletion of my sample(s) as necessary to comply with the Order.

Pursuant to this authorization, please send my sample(s), medical records, and any other information identified in the Order to:

Authorized Recipient: **Foundation Medicine, Inc.**
Address: **150 Second Street**
First Floor
Cambridge, MA 02141

- I understand that unless I specify otherwise, this authorization will remain valid for one (1) year from the date below and that I may revoke this authorization at any time by providing notice in writing to the Pathology Lab, except to the extent that the requested information has already been released in accordance with this authorization.
- I understand that my continued treatment and payment for healthcare is not conditioned on my execution of this form.
- I understand that the information disclosed may be subject to re-disclosure by the Authorized Recipient.
- I understand that, if my tumor tissue sample is in FFPE block form, any tissue remaining after Authorized Recipient's performance of the Test will be returned to the Pathology Lab.

_____ _____

Signature ***Date***

If completed by patient's authorized representative:

_____ _____

Name *(Print)* **Relationship to Patient**

****NOTE: Please submit a copy of this authorization form ONLY to the Pathology Lab (DO NOT send a copy of this authorization form to Foundation Medicine)****