Medical DNA Sample Release Waiver

Date:

Full Name of Donor:

Date of Birth:

Contact Information:

Person/Institution Receiving Sample:

Relationship to Donor (if applicable):

Waiver and Consent

I acknowledge and understand that by signing this waiver, I authorize the release of my medical DNA sample. I confirm that:

- I have been informed of the purpose for the collection and release of my DNA sample.
- I understand the potential risks and implications of releasing my genetic material.
- I have been provided the opportunity to ask questions and receive answers regarding this release.
- I release [Institution/Recipient Name] and its agents from any and all liability associated with the release and use of my DNA sample, except as prohibited by law.

Additional Notes or Conditions:

Signature of Donor:

Date:

Witness Name:

Witness Signature:

Date: