INVITAE

Order cancellation request

FM181-1

Order to cancel
RQ

PATIENT INFORMATION

Patient last name	Patient first name		Patient middle initial	Patient DOB (MM/DD/YYYY)
Address				
City	State	Zip code	Country	
Home phone	Email			

- I understand that a test can only be cancelled prior to report release.
- I further understand that at the time of this request Invitae may have already identified medically actionable findings in the test and I hereby confirm the request to cancel regardless of any potential findings. I acknowledge that I will not receive any further information from Invitae regarding any potential findings.

Signature	Date
Printed name	I am the (select) ◯ **Patient** ◯ **Healthcare provider** ◯ **Patient representative**

PATIENT REPRESENTATIVE (IF APPLICABLE)

If you are the personal representative of the patient, complete the section below and include a copy of legal documentation showing that you are the parent, guardian, executor, or have medical decision-making authority.

Name			Relationship to patient
Address			Phone
City	State	Zip code	Country