Genetic Counseling Release Form

Please print and sign your name in one of the two places:

Genetic counseling is available to all patients prior to, and up to 1 week following an Amniocentesis/CVS procedure.

I, _____ am aware that genetic counseling is available to me at the office of Dr. Keith Lescale, M.D. I have decided not to take advantage of this service since all the information needed and all the risks involved with this procedure were explained to me by my obstetrician. I have no additional questions or concerns.

_____	_____
Signature	Date
_____	_____
Print Name	Witness

I, _____ have had or am undergoing genetic counseling at the present time.

_____	_____
Signature	Date
_____	_____
Print Name	Witness

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