PLEASE GIVE THIS INFORMATION TO YOUR PATIENT

Your doctor collected a biopsy as part of your medical care. It is possible your biopsy will be used for research purposes. If so, your biopsy and health information will be labeled with a code. Your name and other information will be removed for privacy. If you **do not** wish to participate, please sign below and return this form to your clinic care team.

Print Name _______________________ DOB________ Signature______________________________

Clinic Staff, please return form to University of Minnesota Oral Pathology Laboratory with biopsy

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