Patient Informed Consent for Genetic Testing

Patient Name: _____ **Date of Birth:** _____

I authorize a performing lab to conduct genetic testing for _____ (Disease and/or Test Name), as ordered by my or my child's physician or authorized healthcare provider, and authorize the collection of a sample for the purpose of that testing. I acknowledge and consent to the following:

1. My physician or his/her designee (such as a genetic counselor) has fully covered the following:

(a) purpose, description and nature of the test and its potential uses;

(b) reliability of positive or negative results and the level of certainty that a positive test result for the disease or condition serves as a predictor of such disease, the effectiveness and limitations of the genetic test and the meaning of the genetic test results;

(c) implications of taking the genetic test, including the medical risks and benefits;

(d) description of the disease or condition tested for;

(e) the availability and importance of genetic counseling. I acknowledge that I have been provided with information identifying a genetic counselor or medical geneticist from whom I might obtain such counseling and understand that I may seek counseling prior to signing this consent; and

(f) a positive test result is an indication that I may be predisposed to or have the specific disease or condition tested for and I understand that I may wish to consider further independent testing, consult with my physician or pursue genetic counseling to discuss the test results.

2. I authorize my test results to be disclosed to the following person(s): _____
I understand that I will receive the test results from my physician unless I direct otherwise. I understand that I have a right to confidential treatment of my sample and results and that my test results will only be disclosed as authorized in this consent.

3. Test results will be retained in accordance with applicable laws. I understand that only my physician's office and/or performing lab will have access to my sample and that my sample will be used only for the purposes for which I have given my consent.

Patient's Statement
I, the undersigned, have been informed about the test(s) purpose, procedures, possible benefits and risks, and I have received a copy of this consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to genetic testing.

_____	_____	_____
Signature of Patient / Guardian	Printed Name of Patient / Guardian	Date

Healthcare Provider Statement
As the referring physician, I understand the benefits and limitations of this study and have requested that the above-named patient be tested. I attest to the fact that I have provided the patient with the information contained above and fully answered any questions. I believe that the patient understands the information and is voluntarily signing this informed consent.

_____	_____	_____
Signature of Healthcare Provider	Printed Name of Healthcare Provider	Date