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Informed Consent for Genetic Testing

I hereby consent to participate in testing for

Genetic disease: _____

Disease Gene: _____

using a genetic test.

- I understand that a biologic specimen will be obtained from me and/or members of my family.
- I understand that this biologic specimen will be used for the purpose of attempting to determine if I and/or members of my family are affected with this genetic disease/the disease gene.
- I have received an explanation of the limitations of this genetic test. Because of the complexity of genetic testing and the important implications of the test results, results will be reported only through a physician or genetic counselor. The results are confidential to the extent allowed by law. They will only be released to other medical professionals or other parties with my written consent.
- My signature below acknowledges my voluntary participation in this test.
- I understand that the genetic analysis performed is specific only for this disease and in no way guarantees my health or the health of other family members.

Patient Printed Name	Sex ☐ Male ☐ Female	Birth Date

Signature of Patient or Authorized Designee (*required*)	Signature Date

Physician's or Counselor's Statement: I have explained genetic testing (including the risks, benefits, and alternatives) specified to this individual. I have addressed the limitations outlined above, and I have answered this person's questions to the best of my ability. I hereby request genetic testing for above mentioned genetic disease/disease gene.

Reason for Testing List all relevant clinical symptoms and results of any applicable biochemical diagnostic tests: _____

_____

Sample Type: _____

Physician/Counselor Printed Name, Address, Phone, Fax, and Signature	Signature Date