CLARITAS GENOMICS

INFORMED CONSENT FOR GENETIC TESTING

Name of person being tested:_____ Date of Birth:____/____/____

Test Name:_____ Condition_____

1. I understand that the test(s) I have consented to are based on the clinical judgment of my provider.
2. My provider has explained the possible test results and their implications to my/my child's clinical care. In addition, my provider reviewed the clinical sensitivity and specificity of this test for my/my child's suspected condition.
3. My provider has made genetic counseling available to me either him/herself or by referring me to a qualified third party. The benefits and limitations of genetic testing have been discussed with me and I understand that testing is voluntary.
4. I understand that a negative result does not exclude the presence of a genetic condition in me/my child. Results are based on current knowledge and understanding of this gene/test.
5. I understand that these results will be part of my/my child's medical record and will be considered in my/my child's clinical care. Results will only be shared with the provider who ordered the test unless I provide written consent release to additional parties.
6. I understand that my sample will be de-identified after 16 months and possibly used for validation/control studies at Claritas Genomics unless I provide written notice to destroy my sample.

For use in familial testing only:

When performing familial testing, the accuracy and interpretation of results is dependent on familial relationships as described to the laboratory,

I understand the intent of testing a family member is to identify the presence or absence of genetic changes similar to that found in a family member. However, I realize that the laboratory may incidentally identify other specific genetic change(s) that could have clinical implications. If the laboratory does identify an incidental genetic change of possible clinical significance:

☐ I want to be notified

☐ I do not want to be notified

Based on conversations with my provider, I understand that this consent is compliant with current ordering guidelines and/ or state laws. The information in this consent has been explained to me and I understand it. I voluntarily give my authorization and consent to undergo genetic testing

Signature of Person Providing Consent Patient (if 12 years or older and Physician determines signature is appropriate)	**Date:**
Name of Person Providing Consent (please print) Patient (if 12 years or older and Physician determines signature is appropriate)	**Relationship to Patient**
Signature of Provider	**Date:**
Name of Provider (please print)	