Patient Informed Consent for Genetic Testing:

□ I _____ ("Patient"), authorize BayCare to collect specimens for genetic testing as recommended by my healthcare provider. I have been informed of any risks associated with the collection of these samples. I understand that the sample will be used for the purpose of attempting to determine if I have a genetic change associated with a disease. I understand that there may be potential discrimination by long-term disability, long-term care, and life insurance companies based on genetic test results. Results may indicate affected status, increased risk to be affected at a later age, and/or risk to have future affected children with a condition. Additionally, I understand that there is a possibility that this test result may not be able to definitively be interpretative as positive or negative.

I furthermore acknowledge that a healthcare provider or authorized person, such as a genetic counselor, has fully covered the following:

(a) Purpose and description of the test;
(b) Method by which the test will be administered (saliva sample, blood draw, other);
(c) Reliability of positive or negative test results, and the level of certainty that a positive test result for that disease or condition serves as a predictor of such disease;
(d) Availability and importance of further testing, physician consultation and genetic counseling;
(e) A general description of each specific disease or condition tested for; and
(f) The person or persons to whom the test results may be disclosed.

The laboratory performing this genetic test will release the results of this test to the healthcare provider who ordered the test and to other healthcare professionals as specifically indicated on the test requisition form. In addition, I understand that my test results will be released to other individuals or agencies only upon the signed authorization of myself or my authorized individual. In addition, I understand my results will be released to anyone who by law may request and receive test results.

By signing below, the Patient acknowledges that he/she has been given the opportunity to ask questions before signing, and has been told that he/she can ask other questions at any time. Patient also acknowledges that he/she has voluntarily agreed to the genetic testing and is providing his/her consent for the collection of specimens for genetic testing as described above. If patient lacks the capacity to consent, this form will be signed by the person authorized to consent for the patient.

□ I _____ ("Patient"), do NOT authorize BayCare to collect specimens for genetic testing.

_____ _____
Patient Signature/Authorized Individual Date

_____
(Name of Authorized Individual, if applicable)

_____ _____
Witness Signature Date

_____
Name of Witness

Health Provider Statement

By their signature below, the healthcare provider indicates that he or she has explained the purpose of the test, the procedures, the benefits and risks that are involved in testing to Patient. His or her Patient has been given the opportunity to ask questions about this consent. The healthcare provider acknowledges that his or her patient has voluntarily decided to have the test performed.

Healthcare Provider's Authorization to Collect Specimens for Genetic Testing

Patient Name (printed): _____

Patient ID#: _____

Testing Ordered: _____

Healthcare Provider's Signature: _____
Date_____

Printed Name: _____

UPIN or NPI#:_____