MGZ
Medical Genetics Center

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All forms are available on our website:
www.mgz-muenchen.com

INFORMED CONSENT FORM

ilac-MRA DAkkS Deutsche Akkreditierungsstelle D-ML-13242-01-00

- **Patient Last Name, First Name:**
- **Internal Patient or Sample ID:** **Date of Birth:**
- **Clinical Diagnosis / Symptoms:**

PATIENT CONSENT

I hereby consent to genetic testing as indicated on the accompanying test request form and/or to determine the genetic cause of the abovementioned clinical condition.

I have received a thorough explanation from my physician with regard to the disease, its possible genetic origin, and the significance and limitations of the planned genetic test(s). All my questions have been answered and I have had the necessary time to consider giving my consent.

I was informed of and consent to the documentation and interpretation of all test data in accordance with the German laws governing genetic testing, data protection, and patient-doctor confidentiality.

I hereby consent to

☐ *yes* ☐ *no* the sending of my genetic test results to the physician(s) mentioned in the accompanying test request;

☐ *yes* ☐ *no* the forwarding of this test request to a specialized cooperating laboratory (if necessary);

the storage and usage of my personal and medical data as well as the remaining sample material:

- ☐ *yes* ☐ *no* beyond the legally defined period,
- ☐ *yes* ☐ *no* for the purpose of counseling and testing family members with regard to the above-mentioned clinical condition,
- ☐ *yes* ☐ *no* for obtaining test results with new diagnostic possibilities, and
- ☐ *yes* ☐ *no* for verification and quality assurance;

☐ *yes* ☐ *no* the storage and usage of my personal and medical data as well as the remaining sample material for in-house research by MGZ GbR and in pseudonymized or anonymized form for external research by physicians, scientists, research groups, and companies in order to improve the diagnostics and treatment of genetic diseases. I also consent to being contacted by MGZ GbR regarding research opportunities;

☐ *yes* ☐ *no* being informed of additional test results which may be obtained incidentally during the course of genetic testing and which may or may not be related to the abovementioned clinical condition but which could have medically relevant or therapeutic consequences for me and/or my family based on current medical recommendations (such as those of the American College of Medical Genetics and Genomics, or ACMG) and scientific knowledge.

My consent applies to me and/or to my minor child(ren) and can be revoked in whole or in part at any time.

Date	*Signature of Patient or Legal Representative(s)*
Date	*Signature of Requesting Physician*

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