Health insurance or payer		
Last name, first name		Date of birth
Identification no. of payer	Patient's insurance no.	Status
No. of physician's office	Physician's no.	Date

Declaration of consent for genetic examinations

(§8 Genetic Diagnostics Act (Gendiagnostikgesetz))

Indication / requested genetic examination:

Prior to blood sampling I received explanations about purpose, kind, extent, significance and health risks of the genetic analysis according to section 8, subsection 2 of the Genetic Diagnostics Act. I consent that the request for examination and my personal data may be transferred to a specialized cooperating laboratory. I consent that all the collected data may be electronically stored, processed and used by ÜBAG ZOTZIKLIMAS maintaining the protection of data and medical confidentiality.
I had enough time for consideration. I give my permission to the necessary blood sampling and to the above mentioned examination(s). By request, I received a copy of this declaration of consent.

I agree to the storage of sample material for additional examinations or for later verifiability.	☐ yes	☐ no
I agree to the storage of test results for longer than the legal mandatory time of 10 years.	☐ yes	☐ no
I agree to the usage of my test results for consultations and examinations of family members if requested (also beyond my death). *If this consent only applies to individual family members, please name below: ……	☐ yes	☐ no
I agree to the storage and complete usage of my pseudo-anonymized sample material and/or results for scientific purposes (development of methods, publication of cases) and for purposes of quality assurance within the legal framework conditions.	☐ yes	☐ no
In rare cases, genetic information unconnected with the requested examination is obtained (incidental findings). The report of such secondary findings is restricted to pathogenic changes in selected genes with a medical relevance for you and/or your relatives (following the guidelines of the American College of Medical Genetics and Genomics; ACMG SF V2.0; Kalia et al., 2017, PMID: 27854360). There is no claim to a complete analysis of these genes or future re-evaluation. A lack of secondary findings does not equal an exclusion of the corresponding risks. I want to be informed about secondary findings.	☐ yes	☐ no
I agree to the transmission of personal data (e.g. health data, results of genetic tests) to other treating physicians, hospitals and others. *Only to following physicians (name and address): ……	☐ yes	☐ no

I am aware that I may withdraw my consent at any time by written statement and thereby refuse the transmission of results. This will go into effect immediately upon receipt of the written statement.

……	……	……	……
Place	Date	Signature (patient/ legal guardian)	Signature (physician)