Surname, Firstname DOB

Address:

Mitteldeutscher Praxisverbund Humangenetik

Mitteldeutscher Praxisverbund Humangenetik
Friedrichstraße 38 – 40 · 01067 Dresden
E-Mail: info@praxisverbund-humangenetik.de
Tel. Labor: 0351 / 492 78 900 · Fax: 0351 / 492 78 955
Alle Formulare finden Sie unter: www.praxisverbund-humangenetik.de

Declaration of consent for genetic testing according to the German Genetic Diagnostics Act (GenDG)

During the genetic counseling, I had the opportunity to talk to my physician about the disease, the genetic basis and the purpose as well as the scope and type of the genetic testing. All my questions have been answered satisfactorily. I do not have any further questions. By signing the form, I confirm that I have been comprehensively informed and that I agree to the specimen collection and the genetic testing regarding the suspected diagnosis:

_____

The genetic testing may result in incidental findings that are not related to the above-mentioned issue, but may still be of medical importance. There is no claim of a comprehensive analysis including these secondary findings.

Handling of specimens and test results

By signing the form below, I consent to:

- my specimens and test results may be archived for a longer period than the statutory 10 years. But there is no claim for storage.
- my specimens may be stored for quality control purposes in pseudonymous form.
- the test results may be used for scientific purposes in pseudonymous form (e. g. scientific databases).
- my specimens may be forwarded to collaborating medical laboratories (other than the "MVZ Mitteldeutscher Praxisverbund Humangenetik"), if necessary, in addition to the referring physician of the "MVZ Mitteldeutscher Praxisverbund Humangenetik". Every physician else of the "MVZ Mitteldeutscher Praxisverbund Humangenetik" may access to my data in exceptional cases.
- incidental findings, which are not related to the above-mentioned diagnosis, may be disclosed.

- strike out if not applicable –

All personal data and test results are committed to medical privacy and data privacy according to Datenschutzgrundverordnung (DSGVO). I have been informed that I may withdraw my consent entirely or in part at any time.

I agree that a copy of the results of the analysis may be sent to the following physician(s):

_____

name, address, zip code, city

_____

place, date signature of patient/ signature of parent or legal guardian

_____

place, date **responsible physician** (name, signature)

For patients with private health insurance:
I agree that the invoice for the above-mentioned testing will be generated by the "MVZ Mitteldeutscher Praxisverbund Humangenetik" or associated partners. For that purpose, I agree that all relevant data regarding the invoice will be submitted.

_____

place, date signature of patient/ signature of parent or legal guardian