

AOK	LKK	BKK	IKK	VdAK	AEV	Knappschaft
Name, Vorname des Versicherten						geb. am
Kassen-Nr.		Versicherten-Nr.		Status		
Vertragsarzt-Nr.		VK gültig bis		Datum		

Declaration of consent for postnatal genetic examination:

(according to GenDG* a prerequisite for carrying out the examination)

Patient's phone number: _____

Ethnic background: _____

I would like to be tested for genetic alterations in relation to the indication(s) listed to the right using blood (or tissue) taken from me (or the insured person(s) named above):	
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I was informed about the purpose, type, extent and validity of the requested genetic test. I have also been informed of the possible consequences arising from test results. If the requested analysis cannot be carried out in whole or in part at the MVZ Nuremberg/Bayreuth/Ansbach, I agree that the sample material will be sent to other competent partner laboratories and that the analysis will be carried out there on my behalf. I have been informed that variants of uncertain significance (so-called class 3 variants) may be found during the molecular genetic testing and that I will be informed of these. I have had enough opportunity to ask questions regarding this topic. All information I provide and test results are subject to medical confidentiality and will not be disclosed to any third party without my written consent.

I am aware that deliberately incorrectly provided information about the family situation (such as the paternity of a child) can influence the type and extent of the examination and lead to costs that are not covered by health insurance.

The GenDG (*German law for genetic testing) requires the destruction of samples (i.e. biological material) after the examinations have been completed. In contrast to the GenDG, I would like any excess material derived from me to be:

Yes No

- retained for any supplementary analyses which might become medically indicated in the future
- retained and used in anonymous form for quality assurance purposes in the laboratory performing the analyses
- retained and used in anonymous form for scientific purposes
- I would like to be informed of so-called incidental findings of medical relevance

The material will be preserved in compliance with the requirements of the responsible laboratory, the technical feasibilities and stability of the material. I do not have claim on preservation.

Yes No

- I agree that my results may be communicated and forwarded to the following physicians

surname, first name, location

sumame, first name, location

surname, first name, location

sumame, first name, location

- I agree that my results may be communicated to all my 1st, 2nd and 3rd degree relatives
(1st degree relatives are children, parents, siblings and half-siblings; 2nd degree relatives are grandparents, grandchildren, nieces, nephews, cousins, aunts and uncles; 3rd degree are e.g. the children of cousins)

Or

- The results may only be shared with the following family members.

Surname, first name, date of birth

Surname, first name, date of birth

Declaration of consent in accordance with the EU General Data Protection Regulation (GDPR) for the purpose-related processing of personal data:

According to the GDPR, we are obliged to inform you about the purpose for which we collect, store or transmit your personal data. Information about this is available on site and via our website.

With the information available there, the patient is informed that his or her data will be passed on to us (= processor according to Article 28 EU GDPR) and, if necessary, to other external quality-tested laboratories and institutes with special experience in the respective medical issue for the purpose of patient care. Further information on our privacy policy can be found at: www.praenatal.com

I may withdraw this consent in whole or in part at any time without giving justification and request the destruction of the samples. I can also decide at any time not to be informed about the results or to have them destroyed.

Name and signature of the responsible physician: _____

Place, date and signature (patient or if applicable legal guardian for minors): _____

Legal guardian(s) (surname, first name, date of birth): _____