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 and 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. A comprehensive analysis of these secondary findings may not be conducted.

Handling of specimens and test results

By signing the form below, I consent to the following statements:

- My specimens may be archived for result verification purposes or further genetic testing and diagnosing for a maximum time period of 10 years.
- My test results may be archived after the final medical report for a longer time than the statutory period of 10 years. This allows the verifiability of test results. However, claims for storage of specimens and extended archiving of test results cannot be asserted.
- 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. in scientific databases).
- My specimens, if required, may be forwarded to collaborating medical laboratories.
- In exceptional cases, additionally to the referring physician, every other physician of the MVZ Mitteldeutscher Praxisverbund Humangenetik may access my data and inform me about my test results.
- 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 subject to medical confidentiality and the general data protection regulation (GDPR). All medical findings are reported to the submitting physician and will only be disclosed with prior consent. I may withdraw my consent without giving any reason entirely or in part at any time.

In the case that the attending physician is not available, I agree that in medical emergencies a copy of the test results 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** (print name, signature, seal)

For patients with private health insurance:
I agree that the invoice for the above-mentioned testing will be generated by the Privatärztliche Verrechnungsstelle Sachsen (PVS). For that purpose, I agree that all relevant data regarding the invoice will be transferred to the Privatärztliche Verrechnungsstelle Sachsen GmbH.

_____

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