Informed Consent for New York Residents Requesting Genetic Testing

I have been counseled and understand that:

- My health care provider wants me to have a test for: _____
- Patients are required to give informed consent prior to having a genetic test. Prior to consenting to a genetic test, I may find counseling by a genetic counselor or other genetics professional helpful in weighing the benefits and drawbacks of the test. Links to clinical information about the disease my health care provider wants to test for and information about how the test will be performed are available from the DNA Diagnostic Lab's web site: www.hopkinsmedicine.org/dnadiagnostic.
- The genetic tests offered by the DNA Lab are performed to identify variants (gene changes) that may cause or predispose to disease. Targeted tests are performed when a family gene change is known; variant identification or full sequence tests are performed to search for an unknown gene change.
- Genetic tests can be offered to confirm or rule out a diagnosis, to test for a disease before symptoms develop, to determine carrier status or for prenatal diagnosis. My health care provider will tell me about why they would like to order genetic testing.
- A negative genetic test for a disease, in many cases, will not completely rule out that disease. I may still have or be a carrier for that disease. My health care provider will use my health and family history to interpret what the negative result means for me.
- A positive result may mean that I have or am predisposed to developing a genetic disease. There may be additional testing to evaluate or clarify my medical status. I may consult my health care provider or ask to be referred to a genetics professional to discuss any additional testing that would be helpful.
- Results will only be released to authorized personnel.
- When the testing is complete, my de-identified sample may be retained longer than 60 days to be used for quality control purposes or research.

Patient Consent

Signature:	**Date:**
Printed Name:	

Provider Alternate Consent

Signature:	**Date:**
Printed Name:	