Universitätsmedizin Göttingen
Institut für Humangenetik
und
Universitätsmedizin Göttingen
MVZ der UMG, Bereich Humangenetik
Address:
Heinrich-Düker-Weg 12, 37073 Göttingen

UNIVERSITÄTSMEDIZIN GÖTTINGEN UMG

(Patient label, if available)

Health insurance provider or cost bearer		
Last name, First name		Date of birth
Insurance number	Insurance ID number	Status
Institution number	Physician number	Date

Barcode

Consent to genetic testing and processing of personal data in accordance with the German Genetic Diagnostics Act (GenDG), the European Regulation 2016/679 (GDPR), and the Federal Data Protection Act (BDSG)

I consent to the collection and use of samples for genetic testing with regard to the following indication:

Indication: ……

Please indicate how your sample and the results of the analysis may be used (please tick as appropriate ☒ **Failure to tick a box shall be interpreted as „No“**)		
I wish to be informed about the results of the analysis.	Yes	No
In genetic analyses, incidental findings may be detected despite a focus on the primary indication. These findings may not be directly related to the purpose of the test but could have consequences for future life situations (e.g., obtaining insurance, civil service appointments, etc.). There is no claim to completeness. **You have the option to decide individually whether and which incidental findings should be reported:**		
1) I wish to be informed about incidental findings of Group 1 (possible, potentially serious disease in the carrier; risk-reducing or therapeutic measures are available).	Yes	No
2) I wish to be informed about incidental findings of Group 2 (possible, potentially serious disease in the carrier; no risk-reducing or therapeutic measures available). (Note: In prenatal analyses and in children and adolescents, findings of Group 2 are generally not disclosed to protect the right not to know, if the condition only manifests in adulthood and the individual is expected to be capable of giving informed consent at a later time.)	Yes	No
3) I wish to be informed about incidental findings of Group 3 (variants that may lead to a significantly increased risk (≥ 25%) of a serious, early-onset disease in offspring).	Yes	No
I consent to the storage of the biological or DNA sample a) for the purpose of verifying the results and quality assurance, and possibly for the future implementation of new diagnostic methods,	Yes	No
b) for research into the causes and for the improvement of treatment of genetically determined diseases.	Yes	No
I consent to the anonymized publication of the obtained data and its possible reuse.	Yes	No
If necessary, the results of the analysis may be used for the counseling and genetic testing of relatives.	Yes	No
I consent to the storage of the analysis results beyond the legally required period of 10 years. My consent does not constitute an obligation for Humangenetik Göttingen to do so.	Yes	No
I consent to the forwarding of the testing order to a specialized partner laboratory.	Yes	No
I consent to the storage of the results in electronic form (ePA) in accordance with the applicable legal regulations.	Yes	No

I declare that I have received appropriate counseling and have been informed about the possibilities and limitations of the requested analyses, including their potential results and consequences. **I have had sufficient time for consideration.** I have been informed in writing about the purpose-specific processing of my personal data and hereby give my written consent. **This consent may be revoked at any time, in full or in part, in writing** (to the address stated above) (GenDG §8 para. 2). **I may at any time request not to be informed of the test results (right not to know) and/or request the destruction of any results obtained up to the point of revocation. No disadvantages will arise from this**. Services already provided at the time of revocation must be remunerated accordingly. I have been offered a copy of this declaration of consent along with the related information.

X____________________ Place, Date

X____________________ Signature oft he patient / legal representative

X____________________ Place, Date

X____________________ Name of responsible physician (in block letters)

X____________________ Signature

Legal basis: GenDG § 8 para. 1, GDPR Art. 6 sentence 1, GDPR Art. 7, BDSG § 51