Informed Consent Form

I, hereby give my consent for collection of my / my child's biological specimen/s as ticked below for genetic/DNA testing requested:

O Blood O Skin biopsy O Buccal smear

O Amniotic fluid O Chorionic villi O Cord blood

O Stool

- Any other (specify) _____

Quantity collected for testing: _____

I have been explained the process involved in the collection of the specimen by my/ my ward's physician in the case of referrals or myself directly approaching GF for genetic testing. I have understood the entire procedure and hereby permit **Genome Foundation (GF), Hyderabad** to collect sample through clinician /certified phlebotomist/ technician.

I understand that

The information regarding the test and its clinical utility can get from the referral doctor and /or a Genetic counsellor.

a) This test may establish diagnosis / carrier status / genetic susceptibility etc. However, in rare cases, it may turn out to be uninformative.

b) There may be possible sources of error including low level contamination, rare technical errors in the laboratory, rare DNA variants that compromise data analysis, inconsistent scientific knowledge and inaccurate information regarding the clinical diagnosis.

c) The test result will be interpreted as per the guidelines available. However, release of other parts of the remaining data (raw files), if any, can be requested by me or through my healthcare provider within 6 months from the date of report (additional charges may apply).

d) The test reports are released only through the certified healthcare professional(s) listed on the test requisition form or by GF clinicians/ scientists in case of direct consumers since the reports are confidential.

e) I am fully aware, that if I have any questions then I can contact the referral clinician and /or Genome Foundation at the below-mentioned address.

Genome Foundation, #102, Apoorva Towers, Road No: 2, Banjara Hills, Hyderabad – 500 034,
Email ID: info@genomefoundation.in Contact No: 09704899766

f) My medical information and test results will be kept confidential and my identity will not be revealed under any circumstances. The laboratory will use an unique sample coding system and identify my sample/results/reports with the same.

g) I herewith give my consent to Genome Foundation and collaborating National /International scientists/ Institutions for utilizing my test results and associated clinical information including photograph for research and publication in the interest of progress of science. I have the right to deny or permit this consent by ticking *PERMIT/ DENY.*

h) I understand that sections of any of my medical notes may be looked at by responsible individuals from the regulatory authorities where it is relevant in research. I give permission for these individuals to have access to myrecords.

i) I also permit Genome Foundation to preserve remaining biological sample (Banking) as per existing Govt. of India guidelines and use for further testing and/or their in-house/collaborative research in future. I will not seek any monetary benefits from the laboratory as this research information may be beneficial to community/society.

j) I also understand that I am free to withdraw my consent to store the biological sample as stated in item (i) above at any given point of time.

Name & Signature of Patient/ Guardian (<18 years)	**Name & Signature of Clinician /Scientist/ Principal Investigator**
NAME: (Patient/Guardian): Relationship to Patient: Signature: Date: Contact No:	NAME: Reg. No. : Signature: Date: Contact No:
Name & Signature of Witness:	
NAME Relationship to Patient: Signature:	Date: Contact No: