



Medizinisches Versorgungszentrum
Labor PD Dr. Volkmann und Kollegen GbR
Karlsruhe

DECLARATION OF CONSENT

For human genetic analyses according to German Genetic Diagnostics Act (GenDG)

Patient: _____ Date of birth: _____

Postal address: _____

I hereby declare my consent for

- a molecular genetic / molecular cytogenetic / cytogenetic analysis to clarify the diagnosis of

- a predictive (presymptomatic) genetic analysis to clarify the carrier status with regard to
_____ (disease, syndrome)
- for myself
 for my son / daughter

_____ Date of birth: _____

I have been informed about the disease or the possible hereditary disposition, respectively. I have been informed about nature, significance and consequences of the genetic analysis. I have had sufficient time for consideration.

I would like to be informed about the results of the genetic analysis only insofar as it is relevant for the above mentioned question for me and my family. I do not want to be informed about incidental findings.

yes no

I would also ask to be notified about all incidental findings with consequences for me.

yes no

I have been informed that I may cancel my declaration of consent at any time without giving reasons, that I may refrain from getting knowledge of the results of the analysis (right to nescience) and that I may stop the analysis at any time. I also have been informed that I have the right to demand that the material examined as well as all results obtained until then will be destroyed.

I agree that the results of the analysis are also sent to other doctors / persons.

yes no

Name/s: _____

I agree that remaining genetic material (DNA) will be conserved for the purpose of verifiability of the results and for future new diagnostic possibilities for the above mentioned question.

yes no

I agree that remaining genetic material (DNA) in an encrypted (pseudonymised) form may be used for the purpose of quality assurance (as control / reference material in our own laboratory, laboratory comparisons).

yes no

Place, date

Signature patient / parent / legal guardian

Place, date

Signature medical practitioner