LANDSPÍTALI

Consent to the donation of biological sample(s) for paternity and kinship testing

Name of biological donor	
National ID no.	*Address*
Date of biological sampling	*Case category*

1. My signature below confirms that I authorize health care employees of ....
(name of hospital/health care center) to take biological sample(s) upon my presentation of a valid Passport/driver's license.
2. I consent that the DNA obtained from the biological sample(s) may be examined for the purpose of obtaining genetic information for use in paternity or other kinship testing. I permit the use of genetic information obtained from my biological sample(s) in comparison with information obtained from other individuals connected to this testing, for the purpose of kinship testing.
3. I permit the undertaking of genotyping by Landspítali Hospital and that qualified geneticists who are Landspitali Hospital affiliates, may obtain a small part of the DNA material for the genotype testing. I consent that Landspítali Hospital preserves the biological sample(s) and that Landspítali affiliates, qualified geneticists, may also, at their discretion, preserve any genetic material left at the end of the testing, together with the relevant results, for a period of one year after which they will be destroyed. I acknowlegde that the privacy policy of such approved third party genetic specialists is available upon request.
4. I consent to the preservation at Landspítali of the results of the genotype testing and to a copy being sent to the party requesting the testing. The results of the genotype testing will be treated as confidential and will only be made known to Landspítali employees working on paternity testing, approved third party specialists who may be called upon to perform genotype testing, as well as the party requesting the testing or the party's representatives.
5. I consent to the preservation of my biological sample at the Landspitali Hospital for a maximum of five years, regardless of whether the kinship testing has been completed.

Are you a bone marrow transplant recipient? ☐ Yes ☐ No

With my signature I confirm that:
- I have read, understood and consent to the above
- I hereby freely and willingly consent the testing being performed

Date: .... *Biological sample donor:* ....

Guardian signature if biological donor is under 18 years of age:

Date. .... *Guardian:* .... *National ID no.:*......................

<u>**Use EDTA samples glass, 2 - 4 ml. for blood**</u>

Please send mouthswabs or blood samples to this address:
Landspítali - Department of Pathology
House 9 at Barónsstíg, 101 Reykjavík, Iceland
c/o Ritarar - telephone: +354 543 8355

With my signature I verify:
- that the donor has provided a passport and/or driver's license. *ID no.:* ....
- the identity of the biological donor

Employees of Landspítali/Health Care Center: *1)*..

2)..

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