

Center for Human Genetics / Gemeinschaftspraxis für Humangenetik



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Board certified Human Geneticists / Fachärzte für Humangenetik

Patients data (label): male female

Ethnic origin:

Consanguinity of parents:

yes no unknown

.....
Surname, Forename

Information of payment:

.....
Date of Birth Phone

on account,

Invoice address:.....

.....
Street, Number

by form E112 of the European Union,
Please enclose the form E112 on which the national statutory health insurance of the patient has stated to cover the cost.

.....
Postal code City, Country

Test material: EDTA blood sample ml DNA, concentration:ng/µl Other:

Diagnosis or suspected diagnosis:

Diagnostic test requested:

Declaration of Informed Consent to a genetic test in accordance with the German Gene Diagnostics Law from February, 1st 2010 (required for the performance of the test):

With my signature I declare that I was briefed on(date) by.....(physician) about the nature, importance, and implications of the genetic test and that I give my consent to the genetic analyses mentioned above and to the collection of the blood and tissue samples needed for this purpose.

I consent to the storage, in accordance with legal requirements, of the recorded data in paper and/or electronic form and to their use and/or publication in pseudoanonymized form for scientific purposes or for quality assurance.

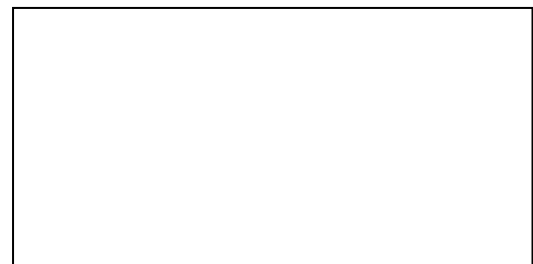
I agree that, contrary to legal requirements, my test results will not be destroyed after 10 years (to allow my family access to them in the event of my death).

I hereby agree to the transfer, in accordance with § 950 BGB (German Civil Code), of any test material remaining at the end of the analysis to the laboratory that carried out the analysis and I consent to its use for scientific purposes in pseudoanonymized form.

I consent to the communication of my data to a medical billing clearing house for invoicing purposes.

I am aware of the fact, that I may withdraw this consent at any time, verbally or in writing, without giving reasons and that this will not have any adverse consequences for me.

- Please delete as appropriate -



.....
City, date

.....
Signature of patient/
Legal representative

Doctor's stamp and signature