Center for Human Genetics / Gemeinschaftspraxis für Humangenetik

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Patients data (label): ☐ male ☐ female

……………………………………………………………………………………………………
Surname, Forename

……………………………… ……………………………………………………………
Date of Birth Phone

……………………………………………………………………………………………………
Street, Number

…………………… ………………………………………………………………………
Postal code City, Country

Ethnic origin: ……………………………………

Consanguinity of parents:

☐ yes ☐ no ☐ unknown

Information of payment:

☐ on account,
Invoice address:…………………………………………………

☐ 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.

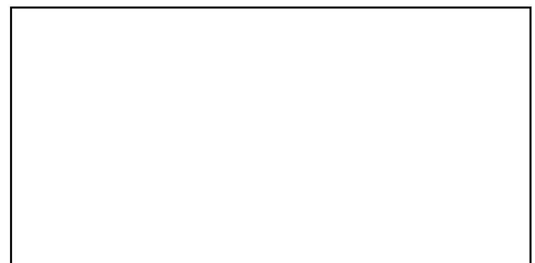
Test material: ☐ EDTA blood sample ………… ml ☐ DNA, concentration: ………….ng/µl ☐ Other: ……………………

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