quadrant laboratories

INFORMED CONSENT & AUTHORIZATION

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Syracuse, NY 13210
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CLIA #33D2218809

PATIENT INFORMATION

Legal First Name	Legal Last Name	Patient Date of Birth *(MM/DD/YYYY)*

Please submit separate signed general consent form for each sample submitted (including parents)

CONSENT TO TEST

I, _____, hereby request genetic testing for me or my dependent

(name of dependent if applicable) _____, which may include genetic molecular or biochemical analyses. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my dependent is about to undergo. I understand that a specimen(s), such as peripheral blood, saliva, cheek swab, dried blood spot, skin biopsy, amniotic fluid, chorionic villi, and/ or urine sample will be taken from me/my dependent. I understand that the samples will be used for determining if I/my dependent have a genetic disease/disorder, are carriers of a genetic disease/disorder, or are more susceptible to develop a genetic disease/disorder or medical condition.

The nature of the genetic testing has been explained to me and the accuracy of the test and its risks and limitations have been detailed. I understand that:

- Although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small, infrequent errors may occur. If the true biological relationships of the family members involved are not as I have stated, this test may detect non-paternity. The likelihood of this occurring has been estimated to be less than 1%.
- A negative result reduces but does not eliminate the possibility that I/my dependent carry a mutation(s) in the gene(s) analyzed or in other gene(s) that are not included in the test. No test will be performed and reported on my sample other than the one(s) authorized by myself and my doctor.
- This testing may yield results that are of unknown clinical significance and that parental or other relative' s specimens may also be tested to determine whether a specific finding was inherited. An error in the diagnosis may occur if the true biological relationships of the family members involved in this process are not as I have stated and this test may detect non-paternity.
- The results of my/or my dependent's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.
- This consent is being obtained in order to protect my right to have all of my questions answered before testing.
- The results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.
- Other laboratories may provide a similar test, and I have had the opportunity to discuss these options with my physician before choosing Quadrant Laboratories.

USE OF PROTECTED HEALTH INFORMATION

I, as the patient or parent/legal guardian of the patient set forth above, authorize Quadrant Laboratories LLC and its agents (collectively, the "Companies") to access, use, and disclose my dependent's protected health information ("Protected Health Information"), including, but not limited to, information relating to my/my dependent's medical condition, treatment, care management, and health insurance, as well as all information provided on this form for activities related to the genetic testing process ("Testing"), including for benefits investigations and prior authorizations, as applicable.

I understand that the laboratory may wish to contact me/my dependent in the future for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my dependent's sample(s). I understand that the laboratory may notify the laboratory to opt out of such future contact.

RESEARCH

I give consent to have my/my dependent's specimen anonymously used for the laboratory quality improvements, scientific research related to genetic disease/disorder and stored for as long as the specimen is useful for such purposes, and that I/my dependent will receive no compensation in connection with such research. Quadrant may also share the de-identified information with its research partners and may submit this de-identified information to research databases for use in scientific and medical research, including scientific databases that are maintained by the federal government. In addition, I give authorization to Quadrant to obtain and use my/my dependent's health information from relevant health information exchanges, which can be accessed through Quadrant's Electronic Medical Record system. Quadrant will then pair my health information with my/my depedent'ssample. The combination of the two will then be completely de-identified, which means that this information will be anonymous, and no one will be able to ever re-identify any of my information. My de-identified information may be used for future research purposes. I understand that I may withdraw this consent at any time and that my/my dependent's specimen will be promptly destroyed; provided however, that actions taken in reliance of this consent may not be cured.

If I prefer not to have any of my/my dependent's de-identified health information used in research databases consistent with this consent, I may initial here _____ or request this by contacting Quadrant by email at support@quadrantlaboratories.com.

ACKNOWLEDGEMENT

I understand that I may revoke this Authorization at any time by contacting support@quadrantlaboratories.com. This Authorization will remain in effect until revoked, unless a shorter period is provided by state law. I understand that such revocation will not apply to any information already used or disclosed in reliance of this Authorization. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way Quadrant Laboratories treats me. I also understand that if I do not sign this Authorization, my dependent will not be able to receive the Testing.

SIGN

Patient signature

Patient printed name

Date *MM/DD/YYYY*

SIGN

Witness signature

Witness initial

Date *MM/DD/YYYY*