Patient Informed Consent for Genetic Testing

I, _____ (Patient's Name) authorize Quest Diagnostics to conduct genetic testing for _____ (Disease and/or Test Name), as ordered by my physician or authorized healthcare provider or my child's or dependent's physician or authorized healthcare provider.

Quest Diagnostics will release the results of the genetic testing only to my physician, or to persons authorized by me or as required by law. I authorize my physician to request on the test order that a copy of my test results be provided by Quest Diagnostics to the following persons:
_____.

Healthcare Provider Statement

By their signature below, the healthcare provider indicates that he or she has explained the purpose of the test, the procedures, the benefits and risks that are involved in testing to their patient. His or her patient has been given the opportunity to ask questions about this consent and seek genetic counseling. The healthcare provider acknowledges that his or her patient has voluntarily decided to have the test performed at Quest Diagnostics.

_____

Signature of Person Obtaining Consent Date

_____

Printed Name of Person Obtaining Consent

Patient's Statement

I, the undersigned, have been informed about the test(s) purpose, procedures, possible benefits and risks, and I have received a copy of this consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to genetic testing.

_____

Signature of Patient Date

_____

Printed Name of Patient

_____

Signature of Parent or Legally Authorized Representative Date

_____

Printed Name of Parent or Legally Authorized Representative Relationship to Patient