ACIBADEM

GENETIC TEST CONSENT FORM

ACIBADEM LABGEN

PATIENT INFORMATION **BARCODE**	**NAME SURNAME:**	**COLLECTION DATE:**	...../...../20.....
		TIME:	.....
	DATE OF BIRTH:	**GENDER:**	☐ FEMALE ☐ MALE
	TELEPHONE:	**TYPE OF SAMPLE:**	
ADDRESS:		☐ Peripheral Blood ☐ Bone Marrow ☐ Cordocentesis ☐ DNA	☐ Amniotic Fluid ☐ Chorionic Villus (CVS) ☐ Paraffin Tissue ☐ .....
E-MAIL: THE E-MAIL ADDRESS OF THE PATIENT OR CUSTODIAN MUST BE WRITTEN LEGIBLY. THE REPORT WILL BE SENT TO THE E-MAIL ADDRESS YOU PROVIDED.			
REFERRING PHYSICIAN **SEAL-SIGNATURE**	**NAME SURNAME:**	**INSTITUTION:**	
	TELEPHONE:	**E-MAIL:**	
CLINICAL INDICATION / FINDINGS /FAMILY HISTORY			

Test:

I have been fully informed about the laboratory tests, resolution of the test, technical specifications, and limitations to be conducted regarding the genetic tests requested by my physician for myself and/or members of my family. I have been informed about the possibility of false positive/negative results, the need to re-run and/or re-analyze the test, the possibility of re-sampling and requesting additional samples, the unsuitability of the material, the use of drugs that may adversely affect the tests, personal and cellular factors, or laboratory-induced culture failures and inability to give results, and rare situations that may occur such as delayed results. I was informed that my sample would be kept in accordance with the regulations. Medical terms were explained, and I was given enough time to ask questions and make decisions. I have read this notification (or it has been read to me by the responsible person) and I understand it. I give permission for additional tests to be performed by the laboratory to increase the reliability of the test the need for further investigation or collaboration with other domestic/international laboratories, to be shared with the physician requesting the test, and the person I have authorized for report submission.

Your personal information and confidentiality will be protected as required by law. Labgen undertakes to keep confidential any patient-specific information, test and analysis results and comments learned or developed during the service period, with the exceptions in the law and other legal regulations and excluding information that has become publicly available, and not to share with third parties. However, matters subject to this confidentiality may be shared with the official authority without informing the patient in the event that they are subject to official processes such as audits, administrative investigations and courts carried out by the authorized institution or requested during these processes and if there is no legal impediment.

I have been informed that my personal data obtained and processed for the purposes specified in the relevant legislation and in this document may be transferred and shared with the companies by Acibadem included in Acibadem Group, authorized representatives, third parties from whom you receive consultancy (domestic and international), and business partners and other third parties with whom they cooperate in order to improve or carry out the services offered, including official authorities, and I also have rights as a data subject within the scope of Article 11 of the Law on the "Kişisel Verilerin Korunması Kanunu" No.6698 that such data may be kept in Acibadem's physical archives and/or information systems, both in digital environment and in physical environment.

I give consent in order to have my sample, results, and information being anonymized and used for educational, scientific research and test verification purposes.

☐ **I accept** ☐ **I do not accept**

Under the light of this information, this is a declaration that I want the requested test to be performed to determine the.....disease (indication)/my child/my child to be born, that I am aware that the responsibilities regarding genetic diagnosis belong to me, that I have given full permission, authorization, and approval to the center with my free will in this regard, and that I fully understand the above-mentioned issues.

Please, write "I have read, I understand and I accept" in your handwriting in this field.

You must indicate your authorization request for report submission preference in your handwriting.
Person authorized to receive information about the results:

PATIENT (Name-Surname/Signature/Date)	WITNESS (Name-Surname/Signature/Date)	DOCTOR (Name-Surname/Signature/Date)