JOHNS HOPKINS MEDICINE

Johns Hopkins Genomics
DNA Diagnostic Laboratory

Informed Consent Supplement

v051524

Patient Information

Patient Name (Last, First):

Date of birth:

MRN:

Test Ordered:

Patient Informed Consent

I grant permission for Johns Hopkins Genomics to perform the genetic test listed on this form for me/my child. The results of genetic testing may be dependent upon the clinical information provided to the laboratory by my physician. The laboratory cannot guarantee turn-around-time. Risks and limitations of this test may include, but are not limited to, disclosure of unexpected family information (non-paternity, consanguinity), uninformative negative results, unexpected findings, and lab error. De-identified clinical or genetic information may be used for quality control purposes, research, and shared in public healthcare databases. Results will be released only to the providers authorized on the test requisition. I understand the benefits, risks, and limitations of this genetic testing.

Patient Signature: **Date:**

Provider Alternate Consent

I, the health care provider requesting the above testing, have explained the benefits and drawbacks of genetic testing to the patient and have obtained verbal consent or an alternate written consent to order the test indicated.

Ordering Provider:

Provider Signature: **Date:**