THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

VERMONT STATE

INFORMED CONSENT FOR GENETIC TESTING

Genetic Testing has been recommended for me (or my child). I understand that the genetic testing requires analysis of the chromosomes, Deoxyribonucleic acid (DNA), Ribonucleic acid (RNA), or protein obtained from a sample of blood, skin, cheek brushings or other body tissues. I understand that no other tests than those authorized will be performed and that my biological sample will not be saved without my authorization.

I understand the specific test that I (or my child) is having and its accuracy. I understand that the results of this test may be inconclusive or uninformative (not tell me anything). I understand that incorrect information about family relationships may affect the test result. I understand that this test may reveal private information such as non-paternity (someone's father not being who they think they are) or adoption. I understand that such information, if obtained through this test, will NOT be revealed to me, my child, or to anyone else, under any circumstances.

I understand that I am responsible for the costs of genetic testing. If I choose to have my (or my child's) insurance company pay for the testing, it is my responsibility to contact the company to determine that they cover such testing. I know that if the insurance company pays for the testing they may have a right to learn the test results. I can choose not to have the insurance company pay for the testing, in which case I will pay for the test myself. I understand that in some cases payment is required before the genetic testing is performed.

Whether it is the insurance company or me that pays for the testing, the results may become part of my (or my child's) permanent medical record. Having this information in the medical record may make it more difficult for me (or my child) to get health, disability, long-term care or life insurance. I have also considered the possible financial impact of the test result.

I understand that Vermont law gives me certain protections from misuse of genetic information, including the right to sue if such misuse occurs.

I have explained to _____ the possible risks, benefits and limitations of

the genetic test _____ (name of the test).

Provider Signature: _____ Date/Time: _____

Institution: _____ Phone number: _____

I have read (or had read to me) the above information and received a copy of this page. All of my questions and concerns about genetic testing have been addressed. I know that I can contact the person above if I have additional questions.

Patient _____ Date/Time: _____

If patient is a minor:

Parent or guardian: _____ Date/Time: _____

Witness: _____ Date/Time: _____