BioMarker Solutions Group (BMSG)

Informed Consent for Diagnostic Testing

By signing below, **I**, the patient having the test performed, acknowledge that:

- I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits and limitations of the diagnostic test(s) to be performed as indicated on the associated test request form or follow-on tests ordered by myself, legal guardian, my healthcare provider or 3rd party sponsor.
- I have discussed with the relevant medical practitioner the reliability of positive or negative test results and the level of certainty that a test result offers in my management (treatment or others).
- I have been informed about the availability and importance of genetic counseling and provided with written information identifying an appropriate healthcare provider from whom I might obtain such counseling, if appropriate.
- I have read this document in its entirety and realize I may retain a copy for my records.
- I consent to being tested for predisposition to hereditary cancer and I will discuss the results and appropriate medical management with my healthcare provider/ genetic counselor or other parties as per local regulations.
- I have been sufficiently informed as to the purpose and procedures of the diagnostic test. I have also been made aware of the utility of my biological material(s) for these purposes and the possibility of exhaustion, loss or use of residual material for commercial use or research and development and hereby relinquish any claim related to such.
- I have been informed that any information, personal or otherwise related to processing (from sample acquisition to release of report) will be anonymized for all processes; and any direct link between myself and such clinicopathological data or outcome(s) will be de-anonymized in accordance with the GDPR whenever appropriate.
- I understand that by signing this document, I acknowledge the afore mentioned, and therefore, agree to undergo the diagnostic test(s) proposed.
- I have been informed that BMSG's "*Privacy policy*" and "*Information Technology Cyber Security Policy*" are available at www.biomarkersolutions.com/activities/compliance/.
- I understand and consent to my PPPI (Personal Patient Privileged Information) and test results will be available to my treating physician, legal guardian, health provider depending on the context of the diagnostic testing being offered.

Physician's/Counselor's/Guardian's/Legal Representative's Statement (SIGNATURE REQUIRED)

I have explained testing to_____ (Print Patient Name).

I have addressed the procedures involved the possible risks and benefits and the limitations outlined above, and I have answered this person's questions.

Physician's/Counselor's/Guardian's/Legal Representative's Signature: _____ Date: _____

Patient Consent to Diagnostic Testing (SIGNATURE REQUIRED)

I, _____ (Print Patient Name), hereby agree to participate in testing for_____ (name of disease/test). This testing will be performed by BMSG.

Patient's Signature: _____ Date: _____

Parent/Guardian Documentation (REQUIRED FOR GENETIC TESTING OF CHILDREN)

I, _____ (print parent/guardian name), hereby give my consent for the participation of (print name of minor child) _____ (Date of Birth: _____), for testing _____ (name of disease/test). This testing will be performed by BMS. By my signature below, I represent that I have the legal authority to consent to medical procedures performed on the minor child named above. I represent that I am the minor child's natural parent or legal guardian and that my parental rights or guardianship have not been terminated or limited in any way by a court or otherwise by law. If I am a natural parent, divorced, unmarried to or legally separated from the other natural parent of the minor child on whose behalf I sign, I represent that I have sole or joint custody of the minor child and that my parental rights have not been terminated or limited in any way by a court or otherwise by law.

Parent's/Guardian's Signature: _____ Date: _____

Authorization for Further Disclosure of Genetic Testing Results

I request that BioMarker Solutions Group send copies of my testing results to the following individuals and/or entities at the following addresses. I understand that the test results contain personal health information and that once my results are disclosed consistent with this authorization, national privacy laws may no longer protect the health information contained in the results. I understand that I have the right to revoke this authorization in the future in a separate, statement indicating my intent to revoke. This authorization is valid as of the date of my signature below and shall remain valid for a period of twelve months beyond that date.

Send results to: (Provide full name and address of each individual to whom results should be sent)

_____

_____

_____

_____

Patient's Signature: _____ **Date:** _____

Note: This Informed Consent can be used singularly or in association with a BMSG test request form or a qualified professional's (e.g.: physicians) prescription.