AUTHORIZATION FOR RELEASE OF PATIENT GENETIC AND GENOMIC DATA

Return to GeneDx by fax: (201) 421-2010 Attention: _____

Or email: support@genedx.com

Unless submitted prior to test completion, your request will be processed within 30 days of our receipt of this completed form. If testing performed generated data on relatives in addition to the patient (i.e. XomeDx trio exome sequencing), complete information on each individual for whom data is being requested. Each individual is required to provide consent for release of his/her data.

PATIENT INFORMATION: (*Indicates required field)

First*	Middle*	Last*	DOB*
Street	City	State	ZIP
Home Phone*	Cell Phone	Business Phone	

Ordering Physician: _____ Date of Collection:_____ GeneDx Accession Number:_____

Relative(s) Information:

To be completed only if data is being requested for a relative. Each individual listed is required to provide consent for release of his/her data.

Relative 1:

First*	Middle*	Last*	DOB*
Street	City	State	ZIP

Ordering Physician: _____ Date of Collection:_____ GeneDx Accession Number:_____

Relative 2:

First*	Middle*	Last*	DOB*
Street	City	State	ZIP

Ordering Physician: _____ Date of Collection:_____ GeneDx Accession Number:_____

Relative 3:

First*	Middle*	Last*	DOB*
Street	City	State	ZIP

Ordering Physician: _____ Date of Collection:_____ GeneDx Accession Number:_____

T: (888) 729-1206 | F: (201) 421-2010 | support@genedx.com | GeneDx.com
207 Perry Parkway | Gaithersburg, MD 20877

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PLEASE RELEASE GENETIC DATA TO:

☐ Self ☐ Healthcare Provider ☐ Researcher† ☐ Other (specify): _____

†If data is being released for research purposes, a separate Research Consent must be signed and submitted.

A secure link to download the requested data will be emailed to the address listed below, unless otherwise specified: _____

(*Indicates required field)

Name*	Email*		
Street	City	State	ZIP
Phone*	Fax Number		

The format of the data file released will be dependent on the type of test performed. Exome and genome data will be provided as CRAM and VCF files. Xpanded and Slice testing data will be provided as an Excel file with the variants; full exome data is available for an additional charge and requires an order by an authorized provider. Other types of testing will be provided in a format appropriate for that test (such as ABI, FASTQ Or FASTA files).

CONSENT (REQUIRED)

I ☐ do ☐ do not give GeneDx permission to discuss my genetic test results with the above named person, if different from patient. (Please select one)

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying GeneDx, LLC at privacy@genedx.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I am a resident of New York and experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

☐ YES, DISCLOSE THIS INFORMATION * ☐ NO, DO NOT DISCLOSE THIS INFORMATION *

Authorized Patient Signature: _____

My purpose/use of the information is for _____

This authorization expires on , 20 ___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____

By my signature below, I authorize GeneDx, LLC to release the above individual's test results to the above address, fax number, or email address provided, or to release the above individual's genetic and/or genomic data to the above address and that I am authorized to make this request.

Authorized Signature of Patient: _____ Date :_____

Signature of Relative 1: _____ Date: _____ Relationship to patient: _____

Signature of Relative 2: _____ Date: _____ Relationship to patient: _____

Signature of Relative 3: _____ Date: _____ Relationship to patient: _____

☐ Power of attorney or other evidence of the person's authority to act as a personal representative of the patient is attached.

PLEASE RETURN THIS FORM TO GENEDX BY FAX, MAIL OR EMAIL:

PATIENT DATA RELEASE: 207 PERRY PARKWAY, GAITHERSBURG, MD 20877 | FAX: 201-421-2010 | EMAIL: SUPPORT@GENEDX.COM

Questions? Call us at 1-888-729-1206 (TOLL FREE) or 301-519-2100

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MYGENE2:

MyGene2 (www.mygene2.org) is a portal through which families with rare genetic conditions who are interested in sharing their health and genetic information can connect with other families, clinicians, and researchers. Families may use MyGene2 to search for and contact other families who have the same condition or mutations in the same gene in order to share information and offer support. Families have the option to make the information they submit to MyGene2 available to anyone visiting the site (i.e., public) or available to only registered users who have also contributed data to MyGene2. Families also have the choice of whether or not they want to be contacted by clinicians and researchers or other families.

Participation is completely optional.

GeneDx can aid in setting up a MyGene2 account for you. By consenting to participate in MyGene2 and providing your email address, GeneDx will share indexed clinical information (HPO terms) based on information submitted by your ordering provider at the time testing was ordered along with reported gene variants. MyGene2 will reach out directly to you via the email supplied below with information on how to set up your MyGene2 account.

☐ Yes, you may send my indexed clinical information and reported gene variants along with my email address to MyGene2.

Authorized Signature of Patient:_____

Patient email (required):_____

☐ No, I do not want to participate in MyGene2.

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