HLA & Molecular Laboratory
7777 Forest Lane, Suite C-740
Dallas, TX 75230
Tel: 972-566-6278

Informed Consent

I ____ authorize Texas Medical Specialty, Inc. to test my blood or tissue sample or my dependent's ___________________________________ sample for genetic conditions. I acknowledge that it has been explained to me that the results of the tests may only be interpreted by my physician and I cannot make the interpretation myself or by using the literature, as there are limitations to what the test can identify.

I acknowledge that I understand that genetic testing results:

-May show that I have a condition or may only be at a risk for a condition
-May show I am be a carrier, meaning someone in my family may be a carrier as well
-Have limitations and therefore, may be inconclusive
-Do not detect all mutations possible for all possible conditions
-May have or may not have any significance, including the negative results
-Have the possibility of errors, the same as any laboratory testing, including genetic testing
-Will not be shared with anyone, unless I request it in writing
-Will only be shared with my physician or genetic consultant (Genetic consultant may have a better knowledge for frequency and implication of the genes)

Confidentiality

-I understand that all of my information and results remain confidential by the staff of Texas Medical Specialty, Inc. and will only be released to my physicians

-I understand that in certain circumstance, the laboratory may not release the results directly to me or my dependent and only release it to my physician

Cost

-I understand that there is a fee for testing and I will be responsible for payment prior to testing begin.

Last Name:_______________________________________ First Name: ______________________________

Date of Birth:______________________________ Patient's MRN__________________________________

(If Applicable)

I request Genetic testing for the condition of:____

Name of referring physician:_______________________________________ Date: _____________________

Signature of patient or guardian: ______________________________ Date: _____________________