Desert Perinatal ASSOCIATES

CONSENT FOR OBTAINING, RETAINING, OR DISCLOSING GENETIC INFORMATION

(e) Except as otherwise provided by federal law or regulation, a person who obtains my genetic information for use in a study shall destroy the information upon completion of the study or my withdraw from the study whichever occurs first, unless I authorize the person conducting the study to retain my genetic information after the study is completed or upon my withdraw from the study.

(f) it is unlawful for a person to disclose my identity if I was the subject of a genetic test or to disclose to another person genetic information that allows the other person to identify me without first obtaining my informed consent, unless the information is disclosed:

(i) To conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;

(ii) To determine the parentage or identity of a person in certain circumstances;

(iii) To determine the paternity of a person in certain circumstances.

(iv) Pursuant to an order of a court of competent jurisdiction;

(v) By a physician after I am deceased and my genetic information will assist in the medical diagnoses of persons related to my blood;

(vi) To a federal, state, county, or city law enforcement agency to establish the identity of a person dead body;

(vii) To determine the presence of certain inheritable preventable disorders in an infant in certain circumstances; or

(viii) By an agency of criminal justice in certain circumstances.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

I, *(Patient Name, please print)* _____, herby give my consent to Desert Perinatal Associates to disclose my genetic information, lab results, ultrasound results and diagnostic testing results, and/or billing information to the following:

- Referring Physician _____
- Spouse/ Significant Other _____
- Other _____

I give permission to leave NORMAL RESULTS on my voicemail/ answering machine / e-mail. Yes_ __ No_ __

If the person tested is unable to sign, please indicate the reason here:_____

_____

_____ _____

Patient Signature or Legal Representative Date

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