Cancer Test Requisition Form

Collection Date (mm/dd/yyyy): _____

Office Use Only:
Date Received: _____

Specimen Type: ☐ Buccal ☐ Blood (2 mL in lavender top tube)
☐ Saliva ☐ Other _____

PATIENT INFORMATION

_____
First Name Middle Name Last Name

_____
Street Address

_____
City State Zip Code

Home Phone: _____ Gender: ☐ Male ☐ Female DOB (mm/dd/yyyy): _____

Ancestry: ☐African American ☐Caucasian ☐Hispanic ☐European ☐Middle Eastern ☐Asian ☐Ashkenazi-Jewish ☐Central/South American
☐Other _____

ORDERING ACCOUNT INFORMATION

_____
Practice Name Provider Name Provider NPI #

_____
Street Address

_____
City State Zip Code

Office Phone: _____ Office Fax: _____ Email: _____

Additional Physician or Genetic Counselor to be copied: Name: _____ Fax #: _____

PHYSICIAN AUTHORIZATION

This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek genetic counseling. The patient has voluntarily decided to have the test performed by myGenomics.

_____ _____
Medical Professional Signature (required) Date (mm/dd/yyyy)

PATIENT AUTHORIZATION

Sign here or on the consent document.

I have read the Informed Consent document and give my permission to myGenomics to perform genetic testing as described. I also give permission for my specimen and clinical information to be used in de-identified studies at myGenomics to improve genetic testing and for publication, if appropriate. My name or other personal identifying information will not be used in or linked to the results of any studies and publications. I also give myGenomics permission to inform me in the future about research opportunities, including treatments for the condition in my family.

☐ Check this box if you want to opt out of research studies. ☐ Check this box if you do not wish to be contacted.
☐ Check this box if you are a NY resident and give myGenomics permission to retain any remaining sample longer than 60 days after the completion of testing.

_____
Patient/Guardian Signature Date (mm/dd/yyyy)

BILLING INFORMATION

Billing Type: ☐ Commercial Insurance ☐ Medicare ☐ Medicaid Prior authorization #: _____

Please complete the following and **attach a copy of the front and back of the patient's insurance card** (include secondary when applicable).

_____ / _____
Primary Insurance Carrier ID# Group # **Secondary** Insurance Carrier ID# Group

_____ / _____
Name of Insured Person Relationship to Patient Name of Insured Person Relationship to Patient

_____ / _____
Insured Date of Birth Start date of coverage Insured Date of Birth Start date of coverage

myGenomics

Patient Name: _____

Date of Birth: _____

PERSONAL HISTORY OF CANCER(S) OR TUMOR(S)

☐ **No Personal History of Cancer/Tumor**

☐ **Breast Cancer** Age of Diagnosis: _____
☐ER ☐PR ☐HER2 ☐Triple Negative ☐Bilateral
☐Two Primaries ☐Invasive Ductal ☐Invasive Lobular
☐DCIS ☐LCIS ☐Other: _____

☐ **Ovarian Cancer** Age of Diagnosis: _____
☐Serous ☐Mucinous ☐Endometrioid
☐ Clear Cell ☐LMP/Borderline
☐Other: _____

☐ **Endometrial Cancer** Age of Diagnosis: _____
☐Serous ☐Mucinous ☐Endometrioid ☐ Clear Cell
☐Sarcoma
☐Other: _____

☐ **Pancreatic Cancer** Age of Diagnosis: _____
☐Adenocarcinoma ☐IPMN
☐Neuroendocrine
☐Other: _____

☐ **Colorectal Cancer** Age of Diagnosis: _____
Location: ☐Right ☐Left ☐Transverse ☐Rectum

☐ **Melanoma** Age of Diagnosis: _____
☐Invasive ☐In-Situ

☐ **Prostate Cancer** Age of Diagnosis: _____
☐Gleason Score: _____
☐Other: _____

☐ **Polyp(s)** Age of First Polyp: _____
☐Adenomatous – total #: _____
☐Other – Pathology: _____ Total #: _____

☐ **Gastric Cancer/Tumor** Age of Diagnosis: _____
Pathology: _____

☐ **Brain Cancer** Age of Diagnosis: _____
Pathology: _____

☐ **Endocrine Cancer/Disease** Age of Diagnosis: _____
☐Thyroid Pathology/Diagnosis: _____
☐Pheochromocytoma (PCC)
☐Paraganglioma (PGL) Location: _____

☐ **Renal Cancer** Age of Diagnosis: _____
☐Bilateral ☐Clear Cell
☐Papillary Type (I or II): _____
☐Transitional Cell ☐Other _____

☐ **Hematologic Disease** Age of Diagnosis: _____
Diagnosis: _____
Status: ☐ Active/Residual Disease ☐ Remission

☐ **Other Cancer/Tumor** _____
Age of Diagnosis: _____

FAMILY HISTORY OF CANCER(S) OR TUMOR(S)

☐ **No Known Family History of Cancer(s) or Tumor(s)** ☐Pedigree Attached ☐Adopted

Please include all clinical details, such as bilateral, pathology (including triple negative breast cancer), premenopausal breast cancer, and Gleason score for prostate cancer, if available.

Relationship	Maternal	Paternal	Cancer/Tumor Site	Age at Diagnosis
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

PERSONAL GENETIC TESTING HISTORY (Please include all copies of tests and related medical records.)

☐ **No Personal History of Genetic Testing**

☐ **Gene(s) Tested:** _____ ☐Positive ☐Negative /_____ ☐Positive ☐Negative / _____ ☐Positive ☐Negative
_____ ☐Positive ☐Negative /_____ ☐Positive ☐Negative / _____ ☐Positive ☐Negative

PREVIOUS FAMILIAL GENETIC TESTING

☐ **No Family History of Genetic Testing** ☐**Relative Tested:** _____ **Gene(s) Tested:** _____

☐**Positive** ☐**Negative** ☐**VUS (Variation of Unknown Significance)**

Patient Name: _____

Date of Birth: _____

☐ **HC0001**	**Adenomatous Polyposis Panel (2 Genes)**	APC, MUTYH Applicable ICD-10 codes may include: ☐D12.0 ☐D12.1 ☐D12.2 ☐D12.3 ☐D12.4 ☐D12.5 ☐D12.6 ☐D12.7 ☐D12.8 ☐D37.4 ☐D37.5 ☐D48.1 ☐D49.0 ☐Z83.71 ☐Z86.010 ☐Z87.39 Other ICD-10 codes: _____
☐ **HC0002**	**Breast Basic Cancer Panel (2 genes)**	BRCA1, BRCA2 Applicable ICD-10 codes may include: ☐C50.929 ☐D05.00 ☐D05.90 ☐D07.30 ☐Z15.01 ☐Z15.02 ☐Z80.3 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.3 ☐Z85.43 ☐Other ICD-10 codes: _____
☐ **HC0003**	**Breast Cancer High/Mod Risk Panel (8 genes)**	ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, TP53 Applicable ICD-10 codes may include: ☐C50.929 ☐D05.00 ☐D05.90 ☐D07.30 ☐Z15.01 ☐Z15.02 ☐Z80.3 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.3 ☐Z85.43 ☐Other ICD-10 codes: _____
☐ **HC0004**	**Breast Cancer Panel (44 Genes)**	ACVR1B, AKT1, ATM, BAP1, BRCA1, BRCA2, CBFB, CDH1, CDKN2A, EGFR, EP300, ERBB2, ERBB3, ESR1, EXOC2, EXT2, FBXO32, FGFR1, FGFR2, GATA3, IRAK4, ITCH, KMT2C, MAP2K4, MAP3K1, MDM2, MUC16, MYC, NCOR1, NEK2, PBRM1, PCGF2, PIK3CA, PIK3R1, PPM1L, PTEN, PTGFR, RB1, RET, SEPT9, TP53, TRAF5, WEE1, ZBED4, Applicable ICD-10 codes may include: ☐C50.929 ☐D05.00 ☐D05.90 ☐D07.30 ☐Z15.01 ☐Z15.02 ☐Z80.3 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.3 ☐Z85.43 ☐Other ICD-10 codes: _____
☐ **HC0005**	**Breast/Ovarian Cancer Panel (21 Genes)**	ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FANCC, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, PTEN, RAD51C, RAD51D, STK11, XRCC2, TP53 Applicable ICD-10 codes may include: ☐C50.929 ☐D05.00 ☐D05.90 ☐D07.30 ☐Z15.01 ☐Z15.02 ☐Z80.3 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.3 ☐Z85.43 ☐Other ICD-10 codes: _____
☐ **HC0006**	**Ovarian Cancer Panel (32 Genes)**	AKT1, ARID1A, BRAF, BRCA1, BRCA2, CBLC, CCNE1, CDK12, CDKN2A, CSMD3, CTNNB1, CUBN, EGFR, ERBB2, FAT3, GABRA6, KIT, KRAS, KREMEN1, MAS1L, MLH1, MSH2, NF1, NRAS, PDGFRA, PIK3CA, PIK3R1, PPP2R1A, PTEN, RB1, TP53, USP16 Applicable ICD-10 codes may include: ☐C50.929 ☐D05.00 ☐D05.90 ☐D07.30 ☐Z15.01 ☐Z15.02 ☐Z80.3 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.3 ☐Z85.43 ☐Other ICD-10 codes: _____
☐ **HC0007**	**Colorectal Cancer Panel (38 Genes)**	ACVR1B, AKT1, APC, ATM, ATP6VOD2, BAX, BRAF, CASP8, CDC27, CTNNB1, DCC, DMD, EP300, ERBB2, FBXW7, FZD3, GPC6, KRAS, MAP2K4, MAP7, MIER3, MLH1, MSH2, MSH3, MSH6, MYO1B, NRAS, PIK3CA, PIK3R1, PTPN12, SLC9A9, SMAD2, SMAD4, TCERG1, TCF7L2, TGFBR2, TP53, WBSCR17 Applicable ICD-10 codes may include: ☐C18.9 ☐C19 ☐C20 ☐C21.0 ☐D01.0 ☐D01.1 ☐D01.2 ☐D01.3 ☐D01.40 ☐D01.7 ☐D01.9 ☐K63.5 ☐Z80.0 ☐Z83.71 ☐Z83.79 ☐Z84.81 ☐Z85.00 ☐Z86.010 Other ICD-10 codes:_____
☐ **HC0008**	**Endocrine Neoplasia Panel (7 Genes)**	CDC73, HRAS, MEN1, PRKAR1A, PTEN, RET, VHL Applicable ICD-10 codes may include: ☐C70.0 ☐C70.1 ☐C70.9 ☐C75.0 ☐C75.1 ☐D09.3 ☐D17.9 ☐D42.9 ☐E21.5 ☐E23.7 ☐Z15.81 ☐Z83.41 ☐Z83.49 ☐Z84.81 ☐Z85.850 ☐Z85.858 ☐Other ICD-10 Codes: _____
☐ **HC0009**	**Endometrial Cancer Panel (12 Genes)**	BRCA1, BRCA2, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, PTEN, TP53 Applicable ICD-10 codes may include: ☐N85.0 ☐N85.00 ☐C54.1 ☐C54.2 ☐Z15.04 ☐Other ICD-10 codes: _____
☐ **HC0010**	**Gastric Cancer Panel (29 Genes)**	APC, ATP4A, BAI3, BRCA2, CCNE1, CDH1, CTNNB1, DCC, ERBB2, FBXW7, FGFR2, GPR78, LPAR2, PRP1B, LRRK2, MET, MYC, NOTCH1, PIK3CA, PRKDC, RET, S1PR2, SPEG, SSTR1, STK11, TP53, TRIO, TRRAP, WNK2 Applicable ICD-10 codes may include: ☐C15.9 ☐C16.9 ☐C17.9 ☐D00.1 ☐D00.2 ☐D05.90 ☐Z80.0 ☐Z84.81 ☐Z85.00 ☐Other ICD-10 codes: _____
☐ **HC0011**	**Li-Fraumeni Syndrome Cancer Panel (2 Genes)**	CHEK2, TP53 Applicable ICD-10 codes may include: ☐C41.9 ☐C49.9 ☐C50.919 ☐C50.929 ☐C71.9 ☐C74.90 ☐D05.00 ☐D05.10 ☐D05.90 ☐D09.8 ☐D43.2 ☐D43.4 ☐Z85.830 ☐Other ICD-10 codes: _____

☐ **HC0012**	**Liver Cancer Panel (33 Genes)**	ALB, AMPH, APC, ARID1A, ARID2, ATM, AXIN1, BAZ2B, BRAF, CCDC178, CDKN2A, CSMD3, CTNNB1, DSE, ELMO1, ERBB2, ERRFI1, GXYLT1, IGF2R, IGSF10, KEAP1, KRAS, MET, NHF1A, OTOP1, PIK3CA, SAMD9L, TP53, UBR3, USP25, WWP1, ZIC3, ZNF226 Applicable ICD-10 Codes may include: ☐C22.8 ☐E83.11 ☐Other ICD-10 codes: _____
☐ **HC0013**	**Lung Cancer Panel (45 Genes)**	AKT1, ALK, APC, ATM, BAI3, BAP1, BRAF, CDKN2A, EGFR, EPHA5, ERBB2, ERBB4, FBXW7, FGFR1, FGFR2, GRM8, KDR, KEAP1, KIT, KMT2D, KRAS, LRP1B, MDM2, MET, MLH1, MUC16, MYC, NF1, NFE2L2, NOTCH1, PDGFRA, PIK3CA, PIK3CG, PKHD1, PTEN, RARB, RB1, RET, ROS1, RUNX1T1, SMAD4, SMARCA4, SOX2, STK11, TP53 + in/del Applicable ICD-10 codes may include: ☐D38.1 ☐C34.80 ☐C34.90 ☐C34.12 ☐C34.81☐C34.82 ☐Z85.118 ☐Z80.1 ☐Other ICD-10 codes: _____
☐ **HC0014**	**Lynch/Colorectal Cancer Panel (8 Genes)**	APC, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN Applicable ICD-10 codes may include: ☐C18.9 ☐C19 ☐C20 ☐C21.0 ☐D01.0 ☐D01.1 ☐D01.2 ☐D01.3 ☐D01.40 ☐D01.7 ☐D01.9 ☐K63.5 ☐Z80.0 ☐Z83.71 ☐Z83.79 ☐Z84.81 ☐Z85.00 ☐Z86.010 Other ICD-10 codes: _____
☐ **HC0015**	**Melanoma Cancer Panel (13 Genes)**	BAP1, BRCA2, CDK4, CDKN2A, MC1R, MITF, NF1, PTEN, RB1, TP53, VH1, XPA, XPC Applicable ICD-10 codes may include: ☐C25.9 ☐C43.9 ☐D01.7 ☐D01.9 ☐D03.9 ☐D04.9 ☐Z80.0 ☐Z80.8 ☐Z84.81 ☐Z85.820 ☐Other ICD-10 codes: _____
☐ **HC0016**	**Pachyonychia Cogenita Panel (9 Genes)**	AAGAB, DSG1, GJB6, KRT6A, KRT6B, KRT6C, KRT16, KRT17, TRPV3 Applicable ICD-10 codes may include: ☐Q84.3☐Q84.4 ☐Q84.5☐Q84.6 ☐Other ICD-10 codes: _____
☐ **HC0017**	**Pancreatic Cancer Panel (16 Genes)**	APC, ATM, BRCA1, BRCA2, CDK4, CDKN2A, EPCAM, MLH1, MSH2, MSH6, PALB2, PMS2, STK11, TP53 , VHL, XRCC2 Applicable ICD-10 codes may include: ☐C25.9 ☐C80.1 ☐D01.7 ☐D01.9 ☐Z80.0 ☐Z84.81 ☐Z85.07 ☐Other ICD-10 codes: _____
☐ **HC0018**	**Prostate Cancer Panel (32 Genes)**	AKAP9, APC, AR, CDK12, CDKN1B, CDKN2A, GLI1, IKZF4, KDM4B, KLF6, KMT2D, MED12, MYC, NCOA2, NIPA2, NKX3-1, NRCAM, OR5L1, PDZRN3, PIK3CA, PTEN, RB1, SCN11A, SPOP, SYNE3, TBX20, TFG, THSD7B, TP53, ZFHX3, ZNF473, ZNF595 Applicable ICD-10 codes may include: ☐D07.5 ☐R97.2 ☐Z15.03 ☐Z80.41 ☐Z80.42 ☐Z84.81 ☐Z85.46 ☐Other ICD-10 codes: _____
☐ **HC0019**	**Renal Cancer Panel (19 genes)**	BAP1, EPCAM, FH, FLCN, MET, MITF, MLH1, MSH2, MSH6, PMS2, PTEN, SDHA, SDHB, SDHC, SDHD, TP53, TSC1, TSC2, VHL Applicable ICD-10 codes may include: ☐C64.9 ☐C65.1 ☐C65.2 ☐C65.9 ☐V16.51 ☐Other ICD-10 codes: _____
☐ **HC0020**	**TruSight Cancer Predisposition panel (94 Genes+284SNPs)**	AIP, ALK, APC, ATM, BAP1, BLM, BMPR1A, BRCA1, BRCA2, BRIP1, BUB1B, CDC73, CDH1, CDK4, CDKN1C, CDKN2A, CEBPA, CEP57, CHEK2, CYLD, DDB2, DICER1, DIS3L2, EGFR, EPCAM, ERCC2, ERCC3, ERCC4, ERCC5, EXT1, EXT2, EZH2, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, FANCM, FH, FLCN, GATA2, GPC3, HNF1A, HRAS, KIT, MAX, MEN1, MET, MLH1, MSH2, MSH6, MUTYH, NBN, NF1, NF2, NSD1, PALB2, PHOX2B, PMS1, PMS2, PRF1, PRKAR1A, PTCH1, PTEN, RAD51C, RAD51D, RB1, RECQL4, RET, RHBDF2, RUNX1, SBDS, SDHAF2, SDHB, SDHC, SDHD, SLX4, SMAD4, SMARCB1, STK11, SUFU, TMEM127, TP53, TSC1, TSC2, VHL, WRN, WT1, XPA & XPC ☐ICD-10 codes: _____
☐ **HC0021**	**Hereditary Single Gene or Gene Set**	Requested Gene(s): _____ ☐ICD-10 codes: _____
☐ **HC0022**	**Variant Testing (previously identified familial mutation)**	Requested Gene(s): _____ ☐ICD-10 codes: _____
☐ **HC0023**	**Focused Exome Testing (5,500 genes)**	☐ICD-10 codes: _____
☐ **HC0024**	**Whole Exome Sequencing TRIO (22,000 genes)**	☐ICD-10 codes: _____
☐ **HC0025**	**Whole Exome Sequencing PROBAND**	☐ICD-10 codes: _____
☐ **HC0026**	**Whole Exome Sequencing Additional Family Member**	☐ICD-10 codes: _____
☐ **HC0027**	**Whole Genome**	☐ICD-10 codes: _____

Informed Consent and Authorization Form

I understand that my health care provider has ordered the following genetic testing for: ☐ Me ☐ My Child

Signature: _____

What is genetic testing?

Genetic testing is an analysis of a person's genetic makeup. Everyone is born with a distinct set of genes that is unique to them. These genes provide instructions for the body to grow and develop. Sometimes a person's genes may be altered during formation and could lead to a specific syndrome, disease or birth defect. Depending on the type of genetic test ordered, a genetic condition or several conditions could be detected that increase your risk of a syndrome, disease and/or defect. Your provider or a genetic counselor should inform you about these conditions for which you are being offered testing. You may also need to follow up with a genetic counselor or your provider to discuss the results after the testing.

What is the purpose of genetic testing?

The genetic test is considered a predictive test if it is performed to identify whether a patient is at an increased risk of developing a hereditary defect or disease but does not determine for certain that a defect or disease will occur. If a genetic test is being performed after a defect or disease has been diagnosed and the test confirms the cause to be in relation to the gene(s), it is considered a diagnostic or confirmatory test.

How is a genetic test performed?

Genetic tests are usually performed by either blood testing or obtaining tissue or cheek cell samples. These samples contain white blood cells that contain your DNA, RNA and important proteins. When testing during pregnancy, chorionic villus, amniotic fluid or a sample of the mother's blood can be used.

What are the limitations of genetic testing?

A genetic test may provide very important information about your health but there are limitations:

- Performing the correct test: If the provider does not have an accurate personal or family history to determine which genetic test(s) are implicated, the incorrect or incomplete test(s) may be ordered.
- Laboratory Processing: All laboratories must meet the proper requirements to process your sample and strict guidelines may be in place to ensure these requirements; however, in rare cases, problems may occur in handling the sample, which might lead to incorrect results.
- Implications of Results: The genetic test may reveal an alteration in a gene or several genes but there may be limits to what is known about each gene and the significance of the result may be uncertain. A genetic alteration or variation cannot determine whether you will actually develop a suspected condition, the timing of its development or the severity of the condition.

It is important that you discuss your genetic test result with your provider so that you can make an informed decision about your next steps.

What are the benefits of genetic testing?

There are several benefits to performing genetic testing. If a genetic variation is determined,

- There may be preventive measures or identified medical treatments that decrease your chances of developing a related genetic syndrome, disease or defect.
- The knowledge can empower a person to make important choices about life planning, even if a cure is not available at the time of testing.
- A person may qualify to enroll in a related research study, which may lead to new treatments.
- It may provide important health information for a person's family.

What are the risks of genetic testing?

There are possible risks of genetic testing:

- Although low risk, there may be a physical risk involved in obtaining the sample for testing.
- There are potential psychological and social risks of testing because they can change a person's life perspective. It may be stressful and there may be an emotional reaction to learning about risks for yourself or your family. This is why it is important to discuss the testing with your provider or a Genetic Counselor before testing.
- There are possible economic risks of genetic testing that may interfere with a patient's ability to obtain health, life, disability or long-term care insurance.
- The genetic test results will become a part of your medical record. If a genetic test is performed, your insurance company may have access to the result.
- There are both state and federal laws that were developed to help protect a person from genetic discrimination, which is the misuse of genetic information. GINA is the Genetic Information Nondiscrimination Act of 2008 and is a federal law that protects individuals from genetic discrimination in health insurance and employment.

What can I learn from my genetic test result?

Results can be classified as negative or positive.

- A negative or "normal" result means the test did not detect a variation or change in the gene(s) tested. This may have limitations in that all genes related to a particular condition may not have been tested. Therefore, a negative test does not always rule out the development of a problematic genetic condition. Also, technology improves every year and there may be new discoveries that are associated with a particular genetic condition that was unknown at the time of testing.
- A positive or "abnormal" result means that you have a genetic change or variation that is related to the development of a specific genetic condition that may put you at an increased risk. However, not all gene variations lead to symptoms or the development of the genetic condition.
- An inconclusive result means that it may fall between a "normal" or "abnormal" range or be "indeterminate." In such cases, this may be labeled as a VUS or *variant of unknown significance*. Even though a change in the gene may be detected, the laboratory may not have enough information to determine if the gene places a person at an increased risk. Laboratories may learn more about that variant in the future and be able to make a more definitive decision about the significance of the gene variation.
- In rare cases, a genetic test may reveal an important genetic variation that is not directly related to the reason a provider ordered the test. These results are called secondary or incidental findings. Examples may include:
  - Non-paternity: The person designated as the father is not the biological father of the person having testing.
  - Consanguinity: The biological parents are closely related by blood.
  - Identification of a condition unrelated to the reason for testing

Result interpretation is based on current and available information present in medical literature, research and scientific databases. Because these resources are constantly changing, new information that becomes available in the future may replace or add to the information myGenomics used to interpret a person's test results. myGenomics does not routinely re-analyze test results that have already been issued and has no obligation to do so. A person may monitor publicly available resources such as ClinVar (www.clinvar.com) to learn about current information about the clinical interpretation of a genetic test.

What happens to my sample after testing?

DNA samples are not returned to a person after the test has resulted. De-identified samples and de-identified test results may be stored in a repository and used for internal validation, educational, research purposes including HIPAA-compliant databases or presented in scientific presentations or papers.

Research with de-identified samples and test data that results in medical advances may have potential commercial value and may be developed and owned by myGenomics or the researchers who analyze the data. If any individual or corporation benefits financially from studying a person's de-identified genetic material, no compensation will be provided to the person or person's heirs.

myGenomics has no obligation to retain a person's sample indefinitely and may destroy it once it no longer has a legal duty to retain it. By consenting to this agreement, I provide authorization for myGenomics and its partners to use my or my child's de-identified sample and test results for such purposes as mentioned above.

Unless opted out on the first page of the requisition, myGenomics may contact me in the future regarding the opportunity to participate in research opportunities, including any available treatment for myself and/or my family.

☐ I understand that I may contact myGenomics via email at info@mygenomics.com or by phone at 1-855-647-4363 if I wish to opt out of future contact or have any questions related to my test results.

☐ I understand that samples from residents of New York State will not be included in the de-identified research studies described in this authorization and will not be retained for more than 60 days after test completion, unless specifically authorized by my selection below. The authorization is optional and testing will not be affected if I do not check the box for the New York authorization language.

☐ **International Specimens:** If my child or I reside outside of the United States, I attest that by providing a sample for testing, I am not knowingly violating any export ban or other legal restriction in the country of my or my child's residence.

☐ **Patient Confidentiality and Genetic Counseling:** It is recommended that my child or I receive genetic counseling before and after the genetic test. Further testing or consultations with a health care provider may still be necessary. To maintain confidentiality, the test results will only be released to the referring health care provider, to the ordering laboratory, to me or other health care providers involved in my or my child's diagnosis and treatment, or to others as entitled by law. The United States Federal Government has enacted several laws that prohibit discrimination based on genetic test results by health insurance companies and employers. In addition, these laws prohibit unauthorized disclosure of this information. For more information, I understand that I can visit www.genome.gov/10002077.

Patient Acknowledgement: By agreeing to this authorization, I acknowledge the following:

- I am either (1) the patient providing the sample and am at least 18 years of age or (2) I have legal authorization to provide this informed consent on behalf of another person.
- I have read and agree to the contents of this form.
- I understand the benefits, risks and limitations of genetic testing.
- I recognize the seriousness of conditions for which testing is being ordered, and that disease descriptions, prognoses, and treatment options have been made available to me by my or my child's health care provider.
- I have been informed of the availability of genetic counseling services. I can find a genetic counselor in my area at: www.nsgc.org.
- I will be given the opportunity to discuss the results of the test with my health care provider, once I receive them.
- I am responsible for informing my ordering health care provider of changes in my or my child's family history.
- I understand that myGenomics may contact me in the future for research opportunities, including treatments for the condition in which my or my child's family. (Please check the box at the end of this Authorization if you wish to opt out of future research opportunities.)
- I understand that myGenomics may use my or my child's de-identified information and test results for validation, educational and/or research purposes, and this de-identified data may be submitted in a HIPAA-compliant manner to research databases.
- For tests or studies that generate data from multiple family members or my spouse or partner, I consent to all of the data being included in a single comprehensive report that will be shared with participating family members, my spouse or partner.
- If myGenomics or a contracted partner of myGenomics (collectively, "myGenomics Partners") is billing my medical insurance carrier directly, I represent that I am covered by insurance and authorize myGenomics Partners to give my designated insurance carrier, health plan, or third party administrator (collectively, "Plan") the information on this form and other information provided by my health care provider necessary for reimbursement, and I authorize Plan benefits to be payable directly to myGenomics Partners.
- I authorize myGenomics Partners to inform my Plan of my test result(s) only if the test result(s) are required for preauthorization of, or payment for, additional testing.
- I will cooperate fully with myGenomics Partners by providing all necessary documents needed for insurance billing and appeals; and understand that I am responsible for sending myGenomics Partners any, and all, of the money that I receive directly from my insurance company in payment for the this test. Reasonable collection and/or attorney's fees, including filing and service fees, shall be assessed if the account is sent to collection, as permitted by state law. I permit a copy of this authorization to be used in place of the original.
- Finally, if I have the legal authorization to provide this informed consent on behalf of another person, I am attesting that the sample provided belongs to that person.

Patient/Guardian Authorization

By my signature below, I attest the following:
I have read and I understand the information provided on this form.
Opt Out for Research and Contact

☐ I do not wish to participate in any research studies.

☐ I do not wish to be contracted by myGenomics for future research opportunities. I understand that my election to opt out of such follow up contacts will not affect my ability to obtain testing.

Authorization of New York Residents

☐ I am a New York state resident and I give permission for myGenomics to retain any remaining sample longer than 60 days after completion of testing and use my de-identified data for scientific and medical research purposes. Such authorization is optional and is not required for testing.

Patient/Guardian Name: _____ _____
First Name Middle Name Last Name Date of Birth: mm/dd/yyyy

Patient/Guardian Signature: _____ Date: _____
mm/dd/yyyy

Health Care Provider's Statement

This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test described above. The patient has been given the opportunity to ask questions and /or seek genetic counseling. The patient has voluntarily decided to have the test performed by myGenomics.

Health Care Provider's Signature _____ Date: _____
mm/dd/yyyy