Main Line Health®

GENETICS & RISK ASSESSMENT PROGRAM/ RELEASE OF INFORMATION AUTHORIZATION

Patient ID

Patient Name: _____ Date of Birth: _____

The Genetics and Risk Assessment Program provides consultations to individuals who may have increased health risks due to their family or personal history. By signing this form, you acknowledge that you will be provided with an educational risk assessment and genetic counseling based on the information you provide regarding your medical and family histories. Should this information suggest a potential hereditary risk the option of genetic testing (using a clinical or research laboratory) will be offered. Individuals proceeding with genetic testing will sign an additional consent form as required by the laboratory performing the test.

Some individuals may benefit from learning their risk(s), which may lead to altering risk management practices. This information could promote increased surveillance in higher risk individuals, lead to discussions of risk reduction options, or the cessation of unnecessary risk management practices in lower risk individuals. Some individuals may experience anxiety or depression in reaction to learning their risk(s) or that there could be a hereditary component related to certain health conditions in their family.

DISCLOSURE OF HEALTH INFORMATION

As part of the risk assessment, various types of genetic information may be obtained. Your genetic information, including but not limited to, medical and family histories, pedigree, disease or disorder manifestations, risk factors, risk management guidelines, genetic testing lab results and summary notes ("Genetic Information"), will be included in your medical record.

Your Genetic Information will be provided to your referring physician, _____ (name of referring physician) and to additional health care providers you identify below. Please list the additional health care providers to whom you request Main Line Health to release your Genetic Information at this time:

Provider Name	Provider Address	Provider Phone Number

In addition to the health care providers named above, your Genetic Information may be used and/or disclosed for purposes consistent with permitted uses outlined in Main Line Health's Notice of Privacy Practices, including, but not limited to, for treatment purposes. The Notice of Privacy Practices is available on the Main Line Health website at www.mainlinehealth.org. The Genetic Information provided to your referring physician (and to any of your other health care providers) may become a permanent part of your medical record kept by that physician and/or provider.

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The Genetics and Risk Assessment Program staff will mail to your home a copy of your final chart note and the results of any genetic testing you elect to undergo.

If you wish to authorize the Genetics and Risk Assessment Program staff to discuss or share your Genetic Information with members of your family, friends or others, now or in the future, please notify the program staff and you will be asked to complete a separate authorization form.

I hereby certify that I have read and understand the information presented in the **Genetics and Risk Assessment Program/Release of Information Authorization** (this document). By signing below, I voluntarily and freely consent to participate in this program and hereby authorize Main Line Health to disclose my Genetic Information as described above. I understand that my Genetic Information will become part of my medical record.

I understand that this authorization to disclose my Genetic Information to health care providers as listed above may be revoked in writing at any time, except to the extent that action has already been taken to comply with said authorization. This authorization will automatically expire in six (6) months unless otherwise revoked or indicated here to expire on _____ (date not to exceed six months).

_____ _____

Signature of Patient or Authorized Representative **Date** **Time**

_____

Relationship to Patient

_____

Signature of Witness