PATIENT CONSENT FOR PROACTIVE TESTING

I, _____, request and permit Invitae to analyze the genes indicated on the test requisition form in my sample.

I UNDERSTAND THAT:

1. More information about the Invitae Proactive tests is available from my healthcare provider.
2. The results of this DNA test could be:
   a. Positive, and may:
      i. alert me to a predisposition or an increased risk for developing a genetic disease in the future.
      ii. have implications for risk of disease in other family members.
   b. Negative, and may:
      i. indicate disease risks close to that of the general population but do not eliminate the risk for developing a genetic disease in the future.
3. Molecular genetic tests may or may not provide actionable information or have an implication for my medical management.
4. Some types of DNA changes that could cause a specific genetic disorder may not be detected by this test. As with most molecular genetic tests, Invitae's test has technical limitations that may prevent detection of certain changes due to poor DNA quality, inherent DNA sequence properties, or other types of limitations.
5. There may be possible sources of error including, but not limited to, trace contamination, rare technical errors in the laboratory, rare DNA variants that compromise data analysis, inconsistent scientific classification systems, and inaccurate reporting of family relationships or clinical diagnosis information.
6. Invitae will only interpret the parts of the DNA sequence of the genes indicated on the requisition form by my physician.
7. Invitae's clinical reports are released only to me and the certified healthcare professional(s) listed on the test requisition form. Clinical reports are confidential and will only be released to other medical professionals with my explicit written consent.
8. It is my responsibility to consider the possible impact of my test results as they relate to insurance rates, obtaining disability or life insurance, implications for family members, and employment. The Genetic Information Nondiscrimination Act (GINA), a federal law, provides some protections against genetic discrimination. For information on GINA visit http://www.genome.gov/10002328.
9. The Invitae Proactive tests are screening genetic tests. This means that DNA variants that provide medically relevant information for me or have implications for my medical management will be reported by this test. I may also receive a result that indicates that I carry a genetic change that does not increase my own risk of developing a specific medical condition, but that may be passed within my family (also known as carrier status).
10. I will be offered genetic counseling with a geneticist, genetic counselor or other qualified healthcare provider who can answer questions, provide information and advise about alternatives before and after having this test. Further testing or additional physician consults may be warranted.
11. My data and personal information will be stored and protected in strict confidence complying with regulatory requirements (e.g. HIPAA and equivalent protections), and acknowledge that I have read and understand Invitae's Privacy Policy and Notice of Privacy Practices. My individually identifiable health information (i.e., "Protected Health Information" under HIPAA) will NOT be used in FOR PROFIT research without my additional, explicit consent.
12. Because the understanding of genetic information will improve over time, Invitae may notify me of clinical updates related to my genetic profile (in consultation with my primary clinician as indicated).
13. I have the right to receive a copy of this consent form.

BY SIGNING BELOW, I ATTEST TO THE FOLLOWING:

1. I have been informed of the likelihood of finding a change in the genes for which I am being tested and have received test-specific clinical information.
2. I have read and understand the information provided on this form and have had an opportunity to have any questions answered by my healthcare provider.

Patient signature	Date
Print name of patient	Email address

☐ Check here to opt out of being contacted for research studies (doing so will not affect the care provided to you by Invitae).

HEALTHCARE PROVIDER STATEMENT: By signing below, I attest that I am the referring physician or authorized healthcare professional. I have explained the purpose of test described above. The patient has had the opportunity to ask questions regarding this test and/or seek genetic counseling. The patient has voluntarily decided to have this test performed by Invitae.

Healthcare provider signature	Date