

CONSENT FORM FOR USE OF BIOLOGICAL SAMPLES FOR MOLECULAR GENETIC DIAGNOSTICS AND/OR STORAGE IN THE SE BIOBANK AND FOR RESEARCH PURPOSES

Patient's name:

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Date of birth: Social Security Number (TAJ):

DNA, RNA, and plasma can be isolated from the blood/biological sample taken from me, and the associated data, together with my personal identifiers, can be stored in a coded, pseudonymized, or anonymized form (please underline the appropriate option). In the future, genomic and proteomic analyses related to my disease can be performed using this biological sample.

(please specify the disease)

Molecular biological testing can help diagnose the disease mentioned above, identify risk factors that predispose to it, and determine genetic factors that may influence the effectiveness or side effects of certain medications.

I acknowledge that the test results may not provide sufficient information in the following cases or combinations thereof: 1) absence of blood or tissue samples from key family members; 2) available genetic markers are not informative; 3) technical reasons.

In the event that research yields relevant information regarding my health status or potential future diseases:

- ☐ I wish to be informed of it
☐ I do not wish to be informed of it (Please mark the option appropriate for you!)

The results of genetic testing can be communicated to you personally, together with genetic counseling.

I consent to the use of my blood/tissue sample for:

- ☐ molecular biological diagnostic purposes
☐ research purposes
☐ quality improvement purposes (Please mark the option appropriate for you!)

Biological samples and my clinical data may be stored in the Biobank of the Semmelweis University Biobank Network, Institute of Genomic Medicine and Rare Diseases, under appropriate security and data protection measures. I consent to my biological samples being used by the Semmelweis University Biobank Network or other molecular biology laboratories for research, methodological development, and quality improvement purposes, provided the appropriate research ethics approval is in place. I acknowledge that information regarding my identity will be treated confidentially. My personal data cannot be shared by the Semmelweis University Biobank Network with other institutions unless I provide separate written consent.

I have the right to withdraw my consent at any time without providing reasons and without any negative consequences for my future medical care. This can be done in writing. I

acknowledge that I will not receive any financial compensation for the participation of my biological sample in research or development.

My signature indicates that I have read and understood the patient information and that, with this understanding, I agree to participate in molecular genetic testing and/or biobanking. Semmelweis University will store the biological sample free of charge for a minimum of 5 years and will provide it to me at any time if needed for other diseases. Consent does not exempt the investigators or the relevant institution from legal and professional responsibility. If you require further information on this matter, please consult your attending physician or genetic counselor.

Signature of the patient or legal representative:-----

Witness signature: -----

Name of the physician providing information: -----

Signature of the physician providing information: -----

Date: -----