PRAXIS GENOMICS

6115 Peachtree Dunwoody Rd, Suite 220 | Atlanta, GA 30328 | Phone: 678-837-4022 | Testing information available at www.praxisgenomics.com

Data Release Consent Form

Patient Information

Patient Full Name	Date of Birth

Patient data obtained for the purpose of a diagnosis has been evaluated by Praxis Genomics. We include in final reports any variants determined to be pathogenic, likely pathogenic, or variants of unknown significance (VUS). When VUS data is included into a report, there is some cause to believe it has pathogenic features, usually by referencing gene and genome databases. These findings are disclosed under ACMG guidelines. Reports are generated only for the proband, and not for other samples in the case. For Saphyr Optical Mapping (SOM) and Illumina Short Read (ISR) testing, secondary findings unrelated to the patient's condition or suspected condition will only be reported upon the patient's request based on ACMG recommendations.

All laboratory tests have limitations, and neither SOM or ISR testing is immune from them. There is a possibility that a variant may go undetected by our testing methodologies that causes a condition. This can happen for a few reasons. The pathology community may not yet have a good understanding of the variant's significance. This might be the result of a technical limitation of the testing performed, or a consequence of a degraded sample. Structural variant detection with SOM and Whole Genome Sequencing with ISR are primarily screening tests. Although both testing methods are accurate, data interpretation done on the final report is based on current medical knowledge of the findings, which is incomplete.

Contact Information for Data Release

Full Name of Person Requesting Data
Relationship to Patient (Required)
Email Address (for Data Delivery)
Phone Number
Institution (Required if Provider)
NPI# (Required if Provider)

Data Type Requested

☐ VCF File ☐ BAM File

☐ Other (Specify):_____

Please allow up to two weeks for secure data transfer arrangements to be made. Small files may be trasmitted securely via the listed email address. Praxis Genomics will contact the requester and prepare large files for secure file transfer as appropriate.

Consent

I understand that my or my dependent's raw data for any applicable tests performed by Praxis Genomics is being requested by myself of my healthcare provider. I understand that results will be provided to me or my healthcare provider in the format selected above. I understand that me or my healthcare provider will have access to this data and the relevant testing information therein. I understand that any interpretation of the testing data outside of the Praxis Genomics issued report is at my healthcare provider's discretion.

_____ _____

Signature of Patient, Parent/Guardian, Healthcare Provider. Date