Variantyx Genomic Unity® Comparator* Informed Consent

Patient Name	Date of Birth	Affix barcode label of Patient's sample here

Please fill out the appropriate relative information section on this page when submitting comparator samples. The relative's signature is required in the consent section below. If the relative is affected by the same disorder as the patient, please attach clinical notes describing the relative's clinical phenotypes or complete Supplement A of the test requisition form.
**Comparators are family members of the patient that are submitting samples for genetic evaluation*

Comparator 1: Biological Maternal Information

First Name	Last Name	DOB
Sample Collection Date	Sample Type ❍ Saliva ❍ Blood ❍ Saliva Swab ❍ Genomic DNA	If affected by the same disorder as the patient please list the clinical symptoms:

Comparator 2: Biological Paternal Information

First Name	Last Name	DOB
Sample Collection Date	Sample Type ❍ Saliva ❍ Blood ❍ Saliva Swab ❍ Genomic DNA	If affected by the same disorder as the patient please list the clinical symptoms:

Comparator 3: Other Relative's Information

First Name	Last Name	DOB
Sample Collection Date	Sample Type ❍ Saliva ❍ Blood ❍ Saliva Swab ❍ Genomic DNA	If affected by the same disorder as the patient please list the clinical symptoms:

Family Member Consent

I have discussed the Genomic Unity® test with my healthcare provider including the purpose and procedure, risks, benefits and alternatives. I have been given an opportunity to ask questions about the test, and any questions I had were answered to my satisfaction. I acknowledge that I have sufficient information and understanding to give this informed consent.

1. I give permission to Variantyx and their affiliates to extract and sequence my/my relative's DNA and perform genetic testing for the purpose of improving the interpretation of genetic variants identified in the patient's DNA.

2. I give permission for my anonymized DNA to be used by Variantyx and their affiliates for test development or improvement, internal validation, orthogonal variant confirmation at an outside referral laboratory and/or quality assurance and training purposes.

3. I give permission for my anonymized sample and clinical information to be included in variant and allele frequency databases and publications. My name or other personal identifying information will not be used in or linked to any databases or publications.

4. For NY state residents: ☐ By checking this box I give permission for Variantyx and their affiliates to retain any remaining sample longer than 60 days for testing completion, test development/improvement, internal validation, orthogonal variant confirmation at an outside referral laboratory and/or quality assurance and training purposes.

Biological maternal signature	Date
Biological paternal signature	Date
Other relative's (or authorized individual) signature	Date