NEXT Medicine Study
Research Participant's Authorization to Disclose/Release Genetic Information

Research Participant's Printed Name: _____

Date of Birth_____ Date: _____ Phone #:_____-_____-_____

Research Participant's Authorization: I am a participant in the NEXT (New ExomeTechnology in) Medicine study. I authorize the Principal Investigator, Gail P. Jarvik, MD to allow for the disclosure of my genetic research results to the named person below in the event that I should die or become incapacitated before receiving all genetic research results myself. I understand that my genetic records may contain DNA test results related to my risk to develop genetic conditions and/or may explain why I have a genetic disease. The results are termed "genetic incidental findings" that derive from whole exome sequencing of my DNA. Genetic results information is important for my blood relatives to learn as we share similar genetic material.

This form will be destroyed when all study related genetic results from the NEXT Medicine study are given to me personally.

I give my specific authorization for my genetic results derived from usual care tests or whole exome sequencing tests to be released to the recipient named below: Yes___ No___ (*initial your choice*)

This authorization is valid until _____ (*date*) **OR until the end of the NEXT Medicine study_____**
(initial here)

Research Participant's Rights: I understand I do not have to sign this authorization in order to remain a participant in this research. I may revoke or change this authorization at any time except to the extent already relied upon by sending a request in writing to Dr. Gail Jarvik, MD, PhD, University of Washington Division of Medical Genetics, Box 357720, Seattle, WA 98195-7720. I understand that once the genetic information I have authorized to be disclosed reaches the noted recipient, that person may re-disclose it, at which time it may no longer be protected under privacy laws.

I understand I have the following rights to:

- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected genetic information to anyone
- Continue as a research participant in the New Exome Technology in Medicine (NEXT) Study whether I sign this form or not

By signing this page, I acknowledge that I have read and agreed to the terms of this form.

Research Participant's Signature:

_____ **Date**_____

Recipient Authorized to Receive Information:

Recipient's Printed Name: _____

Relationship to Research Participant:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Telephone:_____ Cellphone:_____ Email:_____