AGREEMENT AND CONSENT FOR OUT OF PROVINCE TESTING

Why am I being asked to sign this Agreement and Consent?

A medical laboratory test only available at a testing site outside of British Columbia ("**Your Test**") has been ordered by your physician. The attached application form ("**Application**") has been completed by your physician and provides information about Your Test.

The purpose of this Agreement and Consent is to:

- ensure that you consent to the collection, use and disclosure of your specimen and personal information in connection with Your Test
- explain the other terms and conditions that apply to the provision of Your Test
- ensure that the removal of your information from Canada complies with the Freedom of Information and Protection of Privacy Act ("**FIPPA**"), if Your Test is performed outside of Canada.

Personal information held by any testing provider located outside of Canada is potentially subject to disclosure demands under the local legal requirements of the country in which the testing takes place. It is important that you understand and agree to this if your information and sample will be sent outside of Canada.

Who pays for out of province testing?

Public funding is available to a BC beneficiary for out of province/out of country laboratory or genetic testing if a funding application is made by your physician and approved. The health agency listed below ("**Health Agency**") has authority to approve Your Test based on medical appropriateness and/or make decisions about whether to approve funding for Your Test. In order to make these decisions, some personal information about you, including the Application and this Agreement and Consent will be provided by your physician to the Health Agency.

Once the Health Agency makes a decision about whether to approve and/or fund Your Test, it will communicate its decision to your physician.

How will my personal information and samples be used and shared?

Arrangements for Your Test may be made by the Health Agency with the out of country/out of province site selected to provide the testing (the "**Test Provider**") upon approval of Your Test. You will be asked to provide your specimen through a local laboratory who will ensure it is provided to the Test Provider. Some personal information about you may need to be shared with the laboratory and the Test Provider for these purposes.

To complete Your Test and report the results to your physician, the following personal information about you must be provided with your specimen to the Test Provider: patient name, date of birth and personal health number. Brief clinical information and information relevant to test interpretation may also be provided, such as medical history, family history, gender and ethnicity (applicable for some genetic tests). This information may be shared verbally, in hard copy or through electronic communication.

Your personal information is collected, used and disclosed by Health Agency under the authority of the *Laboratory Services Act* (BC) and section 26 of FIPPA for the purposes described above. Your personal information may also be collected, used and disclosed to provide payment for Your Test, to evaluate and improve the services provided by the Health Agency, and may be shared with the Ministry of Health for quality improvement and program evaluation purposes.

If you have concerns about the personal information practices of the Test Provider, you should discuss these questions with your physician at the time Your Test application is completed. The Health Agency does not exercise control over these practices.

Who is responsible for the testing and test results?

The Health Agency makes test approval/funding decisions and provides a referral service to Test Providers. The Health Agency relies on the recommendation of your physician that Your Test is medically appropriate and relevant to your care. Your physician is responsible for providing medical advice to you about Your Test and the interpretation of the test results. The Health Agency does **not:**

- offer or provide medical advice to you in connection with Your Test
- perform or supervise testing or interpret the results of Your Test
- provide representations or assurances about the purpose, effectiveness or accuracy of Your Test.

Before you make any medical or other decisions about whether to participate in Your Test or based on the results of Your Test, you should discuss your options with your physician and other advisors.

By signing below, you acknowledge and agree:

- **that the Health Agency may collect, use and disclose your personal information as set out above, including by providing your personal information and sample to a Test Provider who may use and store this information outside of British Columbia or, as applicable, outside of Canada;**
- **that the Health Agency is not responsible for and shall not be liable for: the accuracy, completeness or quality of Your Test; Your Test results or their interpretation; or the act or omissions of the Test Provider or your physician, including negligent acts or omissions;**
- **that any disputes, complaints, claims, liabilities or other issues of concern regarding the performance or delivery of Your Test, the collection, use or disclosure of your personal information by the Test Provider, the review and interpretation of Your Test results or your reliance on such results ("Claims") are solely between you, your physician and the Test Provider; and**
- **to waive, release and discharge the Health Agency from such Claims and will not commence or bring or make any claim, demand, action or legal proceeding against the Health Agency for or in connection with such Claims.**

Any questions concerning this Agreement and Consent should be directed to the Corporate Director, Information Access & Privacy at 1-855-229-9800 or privacyandFOI@bccss.org. Any questions about your treatment or care can be directed to your physician.

Health Agency: **BC's Agency for Pathology and Laboratory Medicine**

Signatures:

Patient (or Substitute Decision Maker*) Signature	Witness Signature
Patient Name (Print)	Witness Name (Print)
Substitute Decision Maker* Name (Print), if applicable	Date (MMM – DD - YYYY)
Reason for Substitute	

**For the purpose of this consent a substitute decision maker may only be a family member or other legally appointed decision maker (e.g., Representative, Committee, Guardian).*

TO BE COMPLETED BY THE PROFESSIONAL INTERPRETER (required only if a professional interpreter is used to obtain consent):

I confirm that I have explained the nature of the above consent to the above-named patient (and/or legal substitute) in the presence of _____ and to the best of my knowledge the context of this consent.
Witness Name (Print)

Signature of Interpreter	Date (MMM – DD - YYYY)
Interpreter Name (Print)	