

Parker University - Consent Form for Case Report

Name of Investigator: _____

Phone Number for Investigator: _____

You are being asked to allow the investigator to use information about your care at Parker University Wellness Clinic to write a case report. Case reports are typically used to share new unique information experienced by a patient during his/her clinical care that may be useful for other physicians and members of the health care community. A case report may be published in print and/or internet dissemination for others to read, and/or presented at a conference. Please read this form carefully. Take your time to make your decision and ensure all your questions have been answered.

The investigator is obligated to protect your privacy and not disclose your protected health information (information about you and your health that identifies you as an individual e.g., name, date of birth, medical record number). When the case report is published or presented, your identity will not be disclosed. Although your personal information collected or obtained will be kept confidential and protected to the fullest extent of the law, there is a limited risk associated with this case report that could result in a loss of confidentiality by virtue of your unique experience.

You will not directly benefit from participating in this case report. However, the information will be shared with other health care professionals and may improve the care that is received by others in the future.

Allowing your information to be used in this case report will not involve any additional costs to you and you will not receive any compensation.

Taking part in this case report is your choice (voluntary). You may choose not to take part or you may change your mind until the case report is published. Once the case report is published, it will not be possible to withdraw it. Your decision will not result in any penalty or change in benefits to which you are entitled including the quality of care you receive.

You will be told about any new information relating to this case report that may affect you.

Your signature below means that you have read the above and had all questions related to it answered. This will permit the investigator to use your clinical information in a case report.

Name of Participant: _____

Caregiver of Participant, if minor: _____

Signature of Participant (or Caregiver)

____ / ____ / 20 ____
Date