**Informed Consent Form for Case Reports**

**Title:**

**Principal Investigator:** **Enter PI Name**

(including affiliation, address, Enter PI Affiliation

and contact phone number) Enter Suite, City, State and Zip

Enter Contact Phone Number

Introduction:

You are being asked to consider allowing enter PI name to use information about your hospital stay and related treatment for your illnesses, and to write what is called a case report. Case reports are typically used to share new unique information experiences by one patient during their clinical care that may be useful for other physicians and members of a health care team. A case report may be published (in print and electronically) for others to read, and/or presented at a conference. This form explains the purpose of this case report. Please read this form carefully and take your time to make your decision and ask any questions that you may have.

Why is this case report being done?

The purpose of this case report is to inform other physicians about the signs, symptoms, course and treatment of insert condition.

What will happen if I agree to be a part of this case report?

Enter PI name will collect information from the medical record to write an academic report on your presentation, course and treatment. Your information being used for this case report includes laboratory values, radiology images, specimen photos, operative reports, pathology reports, and physician notes from your episodes of care related to this illness in the insert name of institution and in insert clinic name-if applicable.

Enter PI name is obligated to protect your privacy and not disclosure your personal information (information about you and your health that identifies you as an individual e.g. name, date of birth, medical records number). When the case report is published or presented, your identity will not be disclosed. No photos or images that could identify you will be used.

Risks:

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.

Benefits:

You will not directly benefit from participating in this case report. The information that can be shared with other health care professionals, however, 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. You will not receive any compensation.

Voluntary Participation:

Taking part in this care report is your choice (voluntary). You may choose not to take part or you may change your mind at any time. However, once the case report is written and published, it will not be possible for you to withdraw it. Your decision will not result in any penalty or loss of 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 information about this Case Report and have had a chance to ask questions to help you understand how your information will be used and that you give permission to allow your information to be used in this case report.

If you have any questions, please contact enter PI name and phone number.

**SUBJECT CONSENT TO PARTICIPATE**

**Case Report Title:**

**Name of Participant:**

Participant/Substitute decision-maker

By signing this form, I confirm that:

* The case report has been fully explained to me and all of my questions have been answered to my satisfaction.
* I have been informed of the risks and benefits, if any, of allowing my information to be used in this case report.
* I understand that efforts will be made to conceal my identity, but full anonymity cannot be guaranteed.
* I have been informed that I do not have to participate in this case report, and this refusal will not affect my medical care in any way.
* I have read each page of this form.
* I authorize access to my personal health information (medical record) as explained in this form.
* I give consent for the material listed in this form to be shown to appropriate health care professional staff, and published in educational publications, journals, textbooks in any form or medium anywhere in the world without time limit.
* I have agreed to participate in this case report, in sound mind, and free of any duress.

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Name of Participant/Substitute Signature Date

Decision-maker (Print)