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| Title of Case Study: |  |
| Author Name(s): |  |
| Name of Institution: | [Medical institution where the patient received treatment] |
| Department/Division: |  |
| Author Contact Information: | [Provide both e-mail and phone number] |

**INTRODUCTION**

You are being asked to allow information about [your/your child’s/your relative’s] hospital stay and/or related treatment of [your/your child’s/your relative’s] condition to be used to write what is a called a case study. A case study is typically used to share new, unique information experienced by one patient during their clinical care with physicians and other health care professionals.

**WHAT WILL HAPPEN IF YOU AGREE TO BE PART OF THIS CASE STUDY?**

Information from [your/your child’s/your relative’s] medical record will be collected to write an academic report on [your/your child’s/your relative’s] clinical presentation, course, and treatment. If you grant permission, the case study author(s) will [publish or present] the case study [in a medical journal or at an upcoming conference/educational event].

The health information requested for use in this case study includes the following:

* [Provide a bulleted list of the patient’s health information to be used for the case study. This may include, for example, results of physical examination, medical history, lab tests, radiology images, specimen photos, operative reports, pathology reports, physician notes, or certain health information indicating or relating to a particular condition.]

The author(s) of the case study are obligated to protect [your/your child’s/your relative’s] privacy and not disclose [your/your child’s/your relative’s] personal information (e.g., name, date of birth, medical record number). When the case study is [published or presented], [your/your child’s/your relative’s] identity will not be disclosed. Any photos or images used in the case study will not contain any identifiable information about [you/your child/your relative].

Taking part in this case study is completely voluntary. You may choose not to take part, or you may change your mind at any time. However, once the case study is [published or presented], it will not be possible for you to withdraw your consent. Your decision will not result in any penalty or loss of benefits to which [you/your child/your relative] are entitled, including the quality of care you receive.

**WHAT ARE THE POSSIBLE RISKS INVOLVED WITH THIS CASE STUDY?**

Identifiable information that is not essential to the case study will not be included. However, there is a small risk associated with this case study that could result in a loss of confidentiality by virtue of [your/your child’s/your relative’s] unique clinical presentation.

**WHAT ARE THE POSSIBLE BENEFITS INVOLVED WITH THIS CASE STUDY?**

[You/Your child/Your relative] will not directly benefit from participating in this case study. However, the information that can be shared with other health care professionals may improve future patient care.

Allowing [your/your child’s/your relative’s] information to be used in this case study will not involve any additional costs to you. You will not receive any compensation for participation.

**WHAT IF YOU HAVE QUESTIONS ABOUT THIS CASE STUDY?**

You have the right to ask, and have answered, any questions you may have about this case study. If you have questions, complaints or concerns, you should contact the case study author(s) listed on the first page of this document.

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**By signing this form, I acknowledge that**:

* (Delete if not applicable) The case study will be published in a [journal, textbook, or specify other educational publication] that can be read [on the internet or in print].
* (Delete if not applicable) The case study will be presented at [a conference or an educational event] and may be audio/video recorded by the event organizer.
* All efforts will be made to conceal [my/my child’s/my relative’s] identity, but complete anonymity cannot be guaranteed. It is possible that somebody, somewhere – perhaps, for example, someone who looked after [me/my child/my relative] in the hospital/clinic, or a relative/friend – may identify [me/my child/my relative].
* My participation in this case study is completely voluntary, and my consent or refusal to participate will not affect [my/my child’s/my relative’s] medical care in any way.
* I can withdraw my consent at any time before [publication or presentation], but once the information has been committed to [publication or presentation] it will not be possible to withdraw my consent. If I wish to withdraw my consent after signing this form, I will contact the case study author(s) listed on the first page of this document.
* A copy of this signed consent form will be provided to me for my records.

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| Signature of patient or patient’s personal representative |  | Date |

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| Printed name of patient or patient’s personal representative *(e.g., patient is a minor, incapacitated, deceased)* |  | If applicable, a description of the personal representative’s legal authority to sign for the patient  |