**Case Report/Series Consent**

Name of person described in article: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information/Photos Collected (list PHI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Report/Series Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical practitioner or corresponding author & degrees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cape Fear Valley Health Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [print full name] give my consent for this information about MYSELF OR MY CHILD OR WARD/MY RELATIVE [print full name]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, relating to the subject matter above (“the Information”) to appear in a journal article, or to be used for the purpose of a thesis or presentation.

I understand the following:

1. The Information will be published without my name/child’s name/relatives name attached and every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after me/my child/relative, if I was in hospital, or a relative - may identify me.
2. I authorize access to my personal health information (medical record) as explained in this form.
3. The Information may be published in a journal which is read worldwide or an online journal. Journals are aimed mainly at health care professionals but may be seen by many non-doctors, including journalists.
4. The Information may be placed on a website.
5. I can withdraw my consent at any time before online publication, but once the Information has been committed to publication it will not be possible to withdraw the consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant/Legally Signature Date

Authorized Representative (print)

I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form clearly understands the nature, involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Obtaining Signature Date

Consent (print)