

INFORMATION FOR PATIENTS

Will you consent to have your information used for research?

Medical researchers aim to understand why some people become sick and others do not, what happens when people become sick, and how best to care for people who are sick. Obtaining patient information for research purposes is critical to improving the quality of your care and the performance of the health care system.

You can decide whether you want any of your identifiable personal information included in the study outlined below. If you decide to allow your personal information to be used or disclosed internally or to a third party (i.e., the principal investigator) for the study, please sign this consent form.

You are free to withdraw your consent at any time without giving a reason. A decision to withdraw or not to take part will not affect the standard of care you receive. Your wish to remove your patient information will be respected unless your personal information has already been made anonymous and can't be identified for removal.

By agreeing to allow your information to be part of the study you are giving permission for the principal investigator and his or her institution to collect, use, and disclose your personal information for the purposes of this research study. Any new research purposes will require new written consent from you.

The principal investigator and employing institution will report and publish research findings and conclusions in a manner that will not identify you, and will not include photographs or visual representations contained in your personal records.

The investigator and employing institution will destroy any individual identities associated with the records as soon as the purposes of the research project have been accomplished, and will notify the practice in writing to this effect. Your personal information will be kept confidential and will be safeguarded to ensure no inappropriate uses or disclosures occur.

If you believe your personal information has been inappropriately collected, used, or disclosed without your consent, you may bring the matter to your practice's privacy officer. If the matter has not been resolved to your satisfaction, you may bring your concern to the College of Physicians and Surgeons of BC, and failing that to the Office of the Information and Privacy Commissioner for BC.

If you have any questions, please contact Doctor _____.

INFORMATION ABOUT THE RESEARCH STUDY

Study Title/Name of Research Project

Purpose of the Study

Research Objectives

Information from your patient records that will be collected, used, and/or disclosed for the purposes of this research study

PATIENT'S CONSENT FOR RESEARCH

If you agree to have your patient information collected, used, and/or disclosed by the principal investigator for the research purposes identified above, please complete the following information and sign below.

Patient's Information

Mr / Mrs / Ms (please circle)		Street Address	
Last Name		City/Town	
First Name		Province	
Personal Health Number		Postal Code	
Date of Birth (mm/dd/yy)		Tel (bus / cell / home)	
Email Address		Fax	

Patient Signature

Date (mm/dd/yy)

Witness or Privacy Officer Name
(please print)

Witness or Privacy Officer Signature

Date (mm/dd/yy)

Principal Investigator's Affiliated or Employing Institution
(please print)

Principal Investigator's Signature

Date (mm/dd/yy)