中華崇仁總醫院暨醫學中心
CHINESE GENERAL HOSPITAL
AND MEDICAL CENTER
EXCEPTIONAL CARE WITHIN REACH

Department of Medical Education and Research
RESEARCH ETHICS REVIEW BOARD (RERB)
Contact#: 8711-4141 local 418 and 481
Email Address: cghmc.irb@gmail.com

CONSENT FORM FOR CASE REPORTS

Case Report Title:

Principal Investigator:

You are being asked to consider allowing Dr. _____ to use information about your _____ to write what is called a case report. Your information being used for this case report includes relevant to this case - history, laboratory findings, photographs and prescribed treatment protocols. A case report may be published in a medical journal (in print and/or via on line) for others to read, and/or presented at a conference. This form explains the purpose of this case report. Please take time to read the following information carefully and ask any questions that you might have.

The purpose of this case report is to inform other physicians that _____.

Your privacy will be protected and your personal information (information about you and your health that identifies you as an individual e.g. name, date of birth, medical record number) will not be disclosed. The information collected will be stored securely and will only be accessible to the named investigators. 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. 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.

Your participation is entirely voluntary, and you may withdraw permission to participate in this case report 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.

Your signature below means that you have read the above information about this form 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 _____ at _____.

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SUBJECT CONSENT TO PARTICIPATE

Case Report Title:

Name of Participant: _____

Participant/Legally Authorized Representative
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 have been informed that I do not have to participate in this case report
- I have read each page of this form
- I authorize access to my personal health information (medical record) as explained in this form
- I have agreed to participate in this case report

_____	_____	_____
Name of Participant/Legally Authorized Representative (print)	Signature	Date

_____	_____	_____
Name of Person Obtaining Consent (print)	Signature	Date