

Clinical Study Consent and Authorization Form

Study Title:

Principal Investigator:

Sponsor:

Introduction

You are being asked to participate in a clinical research study. Please read this form carefully. Ask the study staff any questions you may have before making your decision.

Purpose of the Study

Procedures

If you agree to participate, you will be asked to do the following:

- _____
- _____
- _____

Risks and Discomforts

Potential Benefits

Voluntary Participation and Withdrawal

Participation in this study is voluntary. You may withdraw at any time without penalty or loss of benefits.

Confidentiality

Your records will be kept as confidential as possible. Information collected may be used for research purposes, but your identity will not be revealed.

Authorization

By signing below, you authorize the use and disclosure of your health information as described in this form.

Participant Name: _____

Participant Signature: _____

Date: _____

Investigator/Person Obtaining Consent (Print Name): _____

Signature: _____

Date: _____