



CASE REPORT PATIENT CONSENT FORM

Our clinical team is interested in collecting information about your medical condition and treatment and publishing this information as a case report for other healthcare practitioners, scientists and learners. The purpose of this document is to describe the information we will collect from you and how this information will be used.

Case report

A case report is a detailed report of a unique medical condition and treatment of a patient.

Information collected

The information collected from you may include relevant medical history, laboratory results, images (such as x-rays), photos, and videos (excluding the complete face).

Use of collected information

Your information will be used for improving the treatment of other patients with similar conditions and for educational and research purposes. The information collected from you will be shared with other healthcare providers, researchers, educators, and students. The information will be shared through medical/scientific journals, presentations, poster presentations, and website/internet publications and could be viewed by a worldwide audience, including non-healthcare professionals.

Benefits of participating

You will not directly benefit from participating in this case report. However, your information could help improve the treatment of other patients with similar conditions in the future.

Risks of participating

Your identifiable information that is not necessary for the case report will not be published. A foreseeable risk is that someone may recognize you based on the information published in the case report. If you decide not to participate in the case report, you will continue to receive clinical care as usual.

Your consent or refusal to participate will not affect your medical care in any way.



FLORIDA ATLANTIC UNIVERSITY
Schmidt College of Medicine

By signing this form, I authorize the healthcare provider and other co-authors to write and publish a case report about my treatment.

I _____ (print full name) give consent for the information about me / the patient to appear in a case report.

- I will not receive any financial compensation for participating in this case report.
- I understand that attempts will be made to ensure that my / the patient's health information will be published without identifying information such as names and will be shared with the people who are intended to review it. I also understand that complete anonymity is not possible, and somebody somewhere may recognize me / the patient.
- My / the patient's participation is entirely voluntary, and I can revoke this consent at any time before the publication of this case report. However, once the case report has been published, it will not be possible to withdraw this consent.
- 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 / the patient's information to be used in this case report.
- I have been informed that I / the patient does not have to participate in this case report.
- I have read each page of this form.
- I authorize access to my / the patient's personal health information (medical record) as explained in this form.
- I / the patient have agreed to participate in this case report.

By signing below, I agree that the above information has been explained to me, and I have had the opportunity to ask questions.

Printed name of patient

Signature of patient

Date

IF SIGNING ON BEHALF OF THE PATIENT

My signature below documents that the information in the consent document and any other written information was accurately explained to, and apparently understood by, the patient.

Printed name of authorized representative

Signature of authorized representative

Date

Printed name of person obtaining consent

Signature of person obtaining consent

Date