

Case Report Consent Form

You are invited to allow Dr. **<insert name>** to use information about your **<insert condition/disease/experience>** for the development of a case report. Case reports are a way to share unique information that may assist other health care professionals in improving patient care. This report may be published in print or online and/or presented at a professional conference. Please review this form carefully and contact us with any questions before making your decision about allowing this use of your personal information.

Purpose of the Case Report:

The purpose of this case report is to inform other physicians about **<describe unique aspects of the patient's medical condition and/or their care>**.

Information to Be Used:

Your information for this case report includes **<insert specific details about types of information and sources here >**.

Privacy and Confidentiality:

Dr. **<insert name>** is committed to protecting your privacy. Personal identifiers such as your name, date of birth, and hospital file number will not be disclosed in any publication or presentation. While every effort will be made to maintain confidentiality, due to the uniqueness of your case, there is a small risk of identification.

Risks and Benefits:

You will not receive direct benefits from participating. However, your contribution may help improve the medical care received by other patients in the future.

Costs and Compensation:

There are no costs to you for participating, and you will not receive compensation.

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Däkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, syilx, and T̓silhqot'in Nations where we live, learn, collaborate and work together.

Voluntary Participation:

Participation is entirely voluntary. You may decline or change your mind at any time before the report is finalized. Once the report is shared or published, it will not be possible to remove your information.

Your decision will not affect the quality of care you receive or any benefits to which you are entitled.

Updates:

You will be informed of any new information related to this case report that may affect your decision.

Contact Information:

If you have questions, please contact **<insert name of Case Report author>** at **(XXX) XXX-XXXX** (do not provide a hospital switchboard number).

DOCUMENTATION OF INFORMED CONSENT

By signing below, I agree that:

- The case report has been fully explained to me.
- All my questions have been answered.
- I understand the risks and potential benefits of allowing my information to be used, including that efforts will be made to conceal my identity but my anonymity cannot be guaranteed.
- I understand that participation is voluntary.
- I understand that the case report may be published in a journal, medical book, web site or other form of publication. As a result, I understand that the material may be seen by the general public.
- I have read and understood this form.
- I authorize access to my personal health information as described.
- I agree to participate in this case report.

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Däkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, syilx, and T̓sílhqot'in Nations where we live, learn, collaborate and work together.

Name of person signing
this form (please print)

Signature

Date

If the person signing this form is not the patient, they must be an Authorized Substitute Decision Maker as per IH policy [AL0100 Consent - Adults](#).

If the patient agrees to have images of their face or distinctive body markings published, the following section must be signed in addition to the first section:

- I give permission for images of my face or distinctive body markings to be published and recognize that I might therefore be identifiable even though my name and initials will not be published.

Signature of patient or SDM

Date

Provide a signed copy of the consent form to the patient/SDM for their records.

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Däkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, sylx, and T̓sílhqot'ín Nations where we live, learn, collaborate and work together.