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| **Title** |  |
| **Author/s** |  |
| **Contact Person** |  |
| **Contact Number** |  |
| **Contact Email** |  |

I give my consent for the review of all my medical records that are relevant for the purposes of this report, which has been explained to me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I give my consent for the use of photos / images of me in this clinical case report ***(Note to Authors: Please delete this clause if not applicable to your clinical case report)***

I am aware that the report may be published in a medical journal and/or presented at conferences.

I understand that my name will not be published and that every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. For example, members of my family or the health care staff who have looked after me may recognise me from the details of this case.

I understand that the information collected will be stored securely and will only be accessible to the named authors.

I understand that I can withdraw my consent, but only before the information has been published / presented.

I understand that my decision to participate is voluntary, and if I do not consent to participation, or wish to withdraw my consent, this will not otherwise affect my treatment at the Hospital.

I understand that this Clinical Case Report will be assessed for ethical risks by the secretariat or a sub-committee of the South Eastern Sydney Local Health District (SESLHD) Ethics Committee, and if I have any concerns, I am able to contact SESLHD Research Office via SESLHD-RSO@health.nsw.gov.au.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please print)

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF AUTHOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please print)

SIGNATURE OF AUTHOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF INTERPRETER (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please print)

SIGNATURE OF INTERPRETER (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_