

**PARTICIPANT CONSENT FORM**

**FOR RESEARCH INVOLVING HUMAN SUBJECTS**

**Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Investigators:**

**Additional investigators**:

**You are invited to participate in a research study entitled:**

**Why are these group visits being held?**

**How many people will take part in these group visits? How will they be chosen?**

**What will be involved in the study?**

**What are the risks and benefits of this study?**

**What are my rights as a participant?**

**As a participant in the study, how will my personal information be protected?**

**Are there any costs?**

**SIGNATURES:** Your signature below indicates that you have read this entire Patient Consent Form and that you agree:

* To voluntarily participate in this study.
* To permit the use and disclosure of your personal health information.
* To protect the privacy and confidentiality of personal health information belonging to other participants in the group of which you become aware during group visits.
* That all of your questions have been answered to your satisfaction.
* That you have read this Patient Consent Form and have had time to think about it.
* That you may freely choose to stop being a part of this study at any time.
* That you have received a copy of this Patient Consent Form to keep for yourself.
* By signing this Patient Consent Form, you do not waive any legal rights to which you otherwise would be entitled as a research subject.

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Participant (Print Legibly) Signature of Participant or Legally Authorized Representative

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Witness Signature of Parent or Guardian (required if patient under 18 years old)

I have received a copy of this Patient Consent Form: Initials \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_