Case Report - Patient Consent Form

Name:
MRN:
DOB:

The purpose a case report is to share new unique information experienced by one patient during his/her clinical care that may be useful for other physicians and members of a health care team. A case report may be published in print and/or via internet dissemination for others to read, and/or presented at a conference.

I understand that:

1) We are obligated to protect your privacy and not disclose your personal information (information about you and your health that identifies you as an individual e.g. name, date of birth, medical record number). When the case report is published or presented, your identity will not be disclosed.

2) Although your personal information collected or obtained will be kept confidential and protected to the fullest extent of the law, there is a limited risk associated with this case report that could result in a loss of confidentiality by virtue of your unique experience.

3) Taking part in this case report is voluntary. You may choose not to take part or you may change your mind at any time. However, once the case report is written and published, it will not be possible for you to withdraw it. Your decision will not result in any penalty or loss of benefits to which you are entitled including the quality of care you receive.

4) I will not receive any financial benefits from the publication of this case and allowing your information to be used in this case report will not involve any additional costs to you.

5) The physician has fully explained to me the nature and purpose of a case report, the options and possibility of withdrawal.

6) I certify that I have read and fully understand the information presented in this consent. In addition, I have been afforded an opportunity to ask whatever questions I have regarding the case report. My questions have been answered to my satisfaction.

Comments: _____

[redacted] 2018.7.28

Patient/Authorized Representative (relationship) Date Time

Witness Signature Date Time

TanKaiSeng 陳開盛 28. July, 2018

Physician Signature Print Name Date Time

Principal Investigator: _____

Department: Ritz Digital dental clinic Phone: +886 >675-001>

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Comments: _____

[redacted] 2018.7.26

Patient/Authorized Representative (relationship) Date Time

Witness Signature Date Time

Tan Kai Seng 陳開勝 26 July 2018

Physician Signature Print Name Date Time

Principal Investigator: _____

Department: Ritz Digital dental clinic Phone: +886-6-75-0012