**TEMPLATE CONSENT DOCUMENT WITH HIPAA AUTHORIZATION**

Updated 4/02/2021

**Instructions for Research Team:**

The consent document must be written in commonly used, easily understood language (not above 8th grade reading level is recommended) with all technical terms fully explained in language the participants can be expected to understand, and must clearly present all the information the participant (or legally authorized representative) needs in order to make a reasonable and informed decision concerning voluntary participation.

You may edit the format of this template to suit your needs, but you must include a 1-3/4” margin at the bottom of each page to accommodate the IRB approval stamp. A (version) date must be inserted as a footer on each page shown as month/date/year as well.

Not all research studies involve protected health information (PHI). However, when a study necessarily involves PHI, specific assurances in the form of a HIPAA Authorization must be obtained in order to request/use/disclose PHI of research participants. **If you anticipate collecting PHI from the participants’ healthcare providers for your study, or if your research includes provision of healthcare and thus creation of PHI, use this template**.

**All information in this template are required by the regulations** unless otherwise noted and should be included as appropriate. You may add additional sections to this form as necessary, but you should not delete any statements (other than those bracketed in red or as otherwise instructed).

All fields that require attention appear in RED. For each section that requires attention, please carefully read the additional instructional information that follows that particular field in [bracketed red]. This information may help you determine what to include for each field.

When you use this template for submission to the IRB, you should:

* Fill out all fields appearing in RED and change the text color to black;
* Delete all the instructions that appear in [bracketed red];
* Delete any optional language that appears in RED;
* Delete this instruction page; and
* Ensure appropriate heading and footer appear on each page.

If at any time during this process you have any questions, please do not hesitate to contact the IRB or the HIPAA Compliance Office. We will be happy to assist you.

Institutional Review Board HIPAA Compliance Office

Ross Hall Fourth Floor | Box 70565 Yoakley Hall Third Floor | Box 70285

p: 423.439.6053 p: 423.439.8533

**Title of Research Study**: INSERT TITLE OF RESEARCH STUDY

**Principal Investigator**: INSERT NAME OF PRINCIPAL INVESTIGATOR AND CONTACT INFORMATION FOR PRINCIPAL INVESTIGATOR [Name; Phone: 123-456-7890; email@etsu.edu]

**Organization of Principal Investigator:** East Tennessee State University

**CONSENT FORM**

This Consent Form will explain about being a participant in a research study. It is important that you read this material carefully and then decide if you wish to voluntarily participate.

**SUMMARY**

**[*THE SUMARY SECTION SHOULD ONLY BE INCLUDED IN CONSENT FORMS THAT ARE MORE THAN 4 PAGES LONG*. *Otherwise, start the form at Section A.***

**The information in this section should be a concise and focused presentation of the key information that will help participants understand why one might or might not want to participate. This should be brief yet provide enough information for the potential participant to decide if he/she would like to look into this study further.]**

Here is a brief summary of this study.

* Purpose:
* Duration:
* Summary of Procedures:
* Risks:
* Benefits:

If you are interested in volunteering for this research study, please read the rest of this document.

**STUDY DETAILS**

1. **Purpose:** The purpose(s) of this research study is INSERT SPECIFIC PURPOSE(S)

[State specific purposes of the investigation and a general statement as to its nature, i.e., how it relates to other knowledge and what use may be made of the results obtained. It should be made unmistakably clear whether the study involves an investigational and/or marketed drug or device.]

1. **Duration:** INSERT SPECIFIC DURATION

[State the expected duration of the subject’s participation. For example, if your study includes multiple visits, explain how many visits and how long each will take, and over what time period they will occur. In addition, if the approximate number of participants involved in the study is important to a decision to take part in the research, state the approximate number of participants.]

1. **Procedures:** You will be asked to INSERT PROCEDURES

[Identify any procedures which are experimental. Describe the procedures to be used, including invasive or non-invasive techniques, restrictions on normal activities, possibility of receiving inactive material in a double-blind trial, an identification of any experimental procedures, and specimens to be collected, including frequency and size/amount.]

[If there are anticipated circumstances under which the participant’s participation will be terminated by the investigator without regard to the participant’s consent, the consent process must disclose those anticipated circumstances.]

1. **Alternative Procedures/Treatments:** The alternative procedures or treatments available to you if you decide not to participate in this research study are INSERT ALTERNATIVE TREATMENTS/PROCEDURES

[State any appropriate alternative procedures or course of treatment that might be available or advantageous to the participant. Identify the risks of alternative procedures/treatment. If there are no alternatives, delete this section.]

1. **Possible Risks/Discomforts:** The possible risks and/or discomforts from your participation in this research study include INSERT POSSIBLE RISKS/DISCOMFORTS

[State any known risks, side effects or inconveniences that could be expected as well as risks/discomforts which are not yet known. If applicable, state that the drugs/devices with which you are being treated experimentally are/are not packaged in child resistant containers and should be kept out of reach of children; also, suggest “You should not allow study medication to be taken by anyone but yourself.” If appropriate, list exclusions, e.g., For Females Only: “You should not participate in this study if you are now pregnant or could become pregnant. Should you become pregnant you must notify the study physician immediately.” Alternately, if there are no known or expected risks/discomforts, this must be clearly stated.]

[Statement must be included here if the risk profile of all research-related interventions is **not** well known **or** If the research involves investigational drugs or devices, the consent process must include a statement that the particular treatment or procedure may involve risks to the participant which are currently unforeseeable.]

[Statement must be included here if the research includes pregnant women or women of child bearing potential, the consent process must disclose that the particular treatment or procedure may involve risks to the embryo or fetus, if the participant is or may become pregnant, which are currently unforeseeable unless the risk profile of all research interventions or interactions on embryos and fetuses is foreseeable or there is no reasonable expectation that this research causes risks to fetuses or embryos.]

1. **Possible Benefits:** The possible benefits of your participation in this research study are INSERT POSSIBLE BENEFITS

[Describe potential benefits, which might reasonably result from the research. Identify those to be gained by the individual participant as well as those by society in general. If the individual participant will receive NO direct benefit, this must be stated.**]**

1. **Voluntary Participation:** Your participation in this research is voluntary. ***You may choose not to participate.*** If you decide to participate in this research study, you can change your mind and quit at any time. If you choose not to participate, or change your mind and quit, the benefits or treatment to which you are otherwise entitled will not be affected. You may quit by calling INSERT NAME OF PRINCIPAL INVESTIGATOR, at INSERT PRINCIPAL INVESTIGATOR’S PHONE NUMBER. You will be told immediately if any of the results of the study should reasonably be expected to make you change your mind about continuing to participate.

[Statement must be included here if significant new findings during the course of the research which may relate to the participant’s willingness to continue participation are likely.]

[Statement must be included here if there might be adverse consequences (physical, social, economic, legal, or psychological) of a participant’s decision to withdraw from the research. The consent process must disclose those consequences **and** procedures for orderly termination of participation by the participant.

Indicate that for data already collected prior to the participant’s withdrawal, that the investigator may continue to review the data already collected for the study but cannot collect further information, except from public records, such as survival data. Also indicate that specimens

already used cannot be withdrawn, if applicable.]

1. **Compensation for Research Injury:** If you have an injury while you are in this study, you should call the Principal Investigator immediately. East Tennessee State University (ETSU) will pay the cost of emergency first aid for any injury that may happen as a result of you being in this study. ETSU makes no commitment to pay for any other medical treatment. Claims against ETSU or any of its agents or employees may be submitted to the Tennessee Claims Commission. These claims will be settled to the extent allowable as provided under TCA Section 9-8-307. For more information about claims contact ETSU Office of University Counsel.

[Must in include the above statement verbatim if greater than minimal risk and/or research-related injury is reasonably foreseeable. Otherwise, delete this section in its entirety.]

1. **Financial Costs:** The possible financial costs to you as a participant in this research study are INSERT POSSIBLE FINANCIAL COSTS

[If there are any additional costs to the participant that may result from participation in the research, the consent process must disclose any additional costs. The research team must clearly explain who (which entity) is responsible for any standard/nonstandard treatment of service.]

[If there are no additional costs to the participant you can delete this section altogether.]

1. **Compensation in the Form of Payments to Participant:** INSERT COMPENSATION

[If compensation in the form of payments to the participants is being provided, state the amount, timing and terms of the payment (e.g. check, cash, gift certificate, etc.) precisely. If no compensation in the form of payments is being provided include a statement here indicating the same.

For studies that anticipate an aggregate payment to a single individual of $600 or more, the following information must be included in the informed consent document signed by the subject:

 Personal information about you, including name, address, and social security number, will be released to the University for the purpose of payment and for tax reporting to the Internal Revenue Service (IRS). ETSU will issue you an IRS Form 1099 listing your payment as reportable income.

For studies that anticipate payment via University check, with aggregate payment to a single individual of $100 or more (but less than $600), the following information must be included in the informed consent:

Personal information about you, including name, address, and social security number, will be released to the University for the purpose of payment and for tax reporting to the Internal Revenue Service (IRS), if necessary.

For studies that anticipate payment via University check, gift cards\*, cash or merchandise, with aggregate payment to a single individual of less than $100, the following information must be included in the informed consent:

Personal information about me, including my name and address, will be released to the University for the purpose of payment and for tax reporting to the Internal Revenue Service (IRS), if necessary.

For studies that anticipate payment by a method other than check, such as gift cards\*, cash or merchandise, with aggregate payment to a single individual of less than $100, then the following information must also be included in the informed consent:

You will be asked to sign or initial a form confirming that you received the (insert gift card or cash or merchandise as appropriate). This form will be released to the University for the purpose of payment record-keeping.

\**See exception in “ETSU Payments to Research Subjects” Policy for electronic gift cards when the study is anonymous/confidential.]*

1. **Biospecimens:** The researchers will collect tissue, blood and biospecimens that are important to this study and to future research. If you join this study, the biospecimens given by you to the investigators for this research will no longer belong to you. The research team and sponsor of this research may study your data, tissue, blood, or other biospecimens collected from you. Any product or idea created by the researchers working on this study will not belong to you. There is no plan for you to receive any commercial profit from the creation, use or sale of such a product or idea. If data, tissue, blood, or other biospecimens are in a form that identifies you, the researchers may use them for future research only with your consent or Institutional Review Board (IRB) approval.

[If genetic research may occur with the specimens, include the following paragraph.] Sometimes data and biospecimens are used for genetic research (about diseases that are passed on in families). Even if your data and biospecimens are used for this kind of research, the results will not be told to you and will not be put in your health records. Your data and samples will only be used for research and will not be sold. The research done with your data and samples may help to develop new products in the future, but there is no plan for you to share any commercial profit from such developments. Because your genetic information is unique to you, there is a small risk that someone

could connect the information back to you.

[For research involving biospecimens, describe whether the research will (if known) or might include whole genome sequencing (i.e., sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).]

[This section is required for studies that involve the collection of biospecimens. Otherwise, this section can be deleted in its entirety.]

1. **Confidentiality:** Every attempt will be made to see that your study data and results are kept confidential. The results of this study may be published and/or presented at meetings without naming you as a participant. Your information [and biospecimens] may be de-identified and used for future research studies without your additional informed consent. [**Remove the previous sentence if the study does not collect any identifiable private information or identifiable biospecimens.]** Although your rights and privacy will be maintained, both the research records and signed consent form that identify you may be looked at by others that have the legal right to see that information. This may include the ETSU IRB overseeing this research, other individuals at the University with the responsibility for ensuring we follow the rules related to this research, the federal Office of Human Research Protections (OHRP) that protects participants like you, [ENTITY, the sponsor of this research], and the Principal Investigator and research team. Your records will be kept completely confidential according to current legal requirements and will not be revealed unless required by law, or as described in this form.

[If the study is sponsored, in whole or in part, by the NIH or CDC, the study is automatically issued a Certificate of Confidentiality per terms of the associated award. This informed consent must include CoC language to inform the participant of the parameters of the protection.]

[Mandatory Reporting of Child or Elder Abuse: If there is the possibility that study staff can find elements of abuse during the research procedures (especially studies that involve a home visit), include the following text: “If the study staff finds evidence of child or elder abuse or neglect, we may be required by Tennessee law to report it to local law authorities.”]

1. **Drugs and/or Devices:** Because this study involves test articles regulated by the United States Food and Drug Administration (FDA), the FDA may choose to inspect records which identify you as a participant in this investigation.

[This section is required only if the study involves investigational drugs or devices regulated by the FDA or if data from the study will be submitted to the FDA. Otherwise this section can be deleted in its entirety.]

1. **Clinical Trial:** A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

[This section is required if the study is an applicable clinic trial or federally sponsored clinical trial. Otherwise, this section can be deleted in its entirety.]

1. **Clinically Relevant Research Results:** We will alert you of any clinically relevant research results, including individual results, under the following conditions: [PI to add conditions here] **OR** Any clinically relevant group or individual research results will not be shared with you or any other participant. [Provide explanation why results are not being shared.]

[If your study may involve clinically relevant results, include one of the above statements as appropriate. Otherwise, delete this section in its entirety.]

1. **Contact for Questions:** If you have any questions about the research or experience any problems at any time, you may call INSERT NAME OF PRINCIPAL INVESTIGATOR, at INSERT PRINCIPAL INVESTIGATOR’S PHONE NUMBER, or INSERT ADDITIONAL PERSON TO CONTACT, at INSERT ADDITIONAL PERSON’S PHONE NUMBER. This research is being overseen by an Institutional Review Board (IRB). An IRB is a group of people who perform independent review of research studies. You may also contact the ETSU IRB at 423-439-6054 or IRB@etsu.edu for any issues, questions or input that you may have about the research or your rights as a research participant.

[Must include the above statement for IRB contact information verbatim. You can add other research team contacts or contacts for individuals/groups independent of the research such as a patient advocate.]

**HIPAA Authorization**

**for Disclosure of Protected Health Information for Research**

1. **Purpose**: The purpose of this authorization form is to authorize INSERT NAME OF PRINCIPAL INVESTIGATOR and research team to collect, use, and disclose your protected health information to conduct the research study listed above. This authorization will inform you what information about you may be collected in this study as well as who might see or use your information. INSERT ORGANIZATION WHOSE RECORDS ARE BEING COLLECTED (e.g. East Tennessee State University, Ballad Health, etc.) has rules that require the research team to protect your health information. There are also federal and state laws that protect the privacy of your health information. Generally, only people on the research team will know that you are in the research study and will see your protected health information. However, there are a few exceptions that are listed in Section C of this form.

By signing this authorization form, you authorize the research team to collect, use, and disclose your health information as described in this form. ***You do not have to sign this form***. Your decision not to sign this authorization will not affect your treatment, healthcare, enrollment in health plans, or eligibility for benefits. However, your decision not to sign this form will result in your not being allowed to participate in this research study.

1. **Protected Health Information to be Used/Disclosed:** Protected health information is the information in your medical or other healthcare records. This includes all information in your records that can identify you including your name, address, phone number, birth date, and account numbers.
2. By signing this form you authorize the following healthcare providers, health plans, or other organizations or individuals to disclose your protected health information to the research team:
* INSERT NAME OF HEALTHCARE PROVIDERS/ORGANIZATIONS FROM WHICH THE PI AND RESEARCH TEAM INTEND TO COLLECT PROTECTED HEALTH INFORMATION

[If the research team will be collecting PHI from a particular physician or practice group the particular physician or practice group should be listed here. It is important to note that the authorization will only authorize collection of PHI from the individuals or organizations referenced in this section. Thus, the research team should be careful to include all providers or organizations that they anticipate will have protected health information relevant to the research study. It may be best to identify a class of persons in this section instead of a particular provider e.g. all physicians, or all healthcare providers.]

[If member(s) of the research team will be creating protected health information themselves—e.g. when a member of the research team will be collecting protected health information from his/her own provision of healthcare to the participant prior to or during the course of the study—the research member(s) should include himself/herself in this section in order to use the protected health information he/she creates/created to the research team for the research study.]

[If the research team prefers they may insert a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ here if they anticipate that they will need to write in a healthcare provider or organization during the authorization process.]

1. By signing this form you authorize the individuals or organizations listed above to disclose the following types of protected health information to the research team:
* All records
* Medical history/treatment notes
* Hospital discharge summary
* Radiology records
* Radiology films
* Laboratory/diagnostic tests
* Pathology specimens and slides
* Pathology reports
* Diagnostic imaging reports
* Dental records

[The above are example of items the research team might include. In accordance with the HIPAA Rules we must request the minimum amount of protected health information necessary to accomplish our intended purpose. Thus, the research team should only list types of protected health information that are relevant and required to carry out the research study. “All records” should only be included if in fact all records are necessary to accomplish the purpose of the research study. Otherwise, this section should list the types of protected health information the research team needs to effectively carry out this research.]

[If the research study itself will create PHI—e.g. when a member of the research team will be creating protected health information from his/her own provision of healthcare to the participant prior to or during the course of the study—that research member(s) should be listed in Section B(1) and the following statement or similar statement should be included in this section: “Medical and laboratory records for healthcare rendered in connection with this research study,” along with any other types of protected health information the research team will require.]

[If the research team requires categories of information deemed as “ultrasensitive,” the HIPAA Rules require a specific request to be included in this authorization. If none of the categories of ultrasensitive information are needed you may delete the paragraph below in its entirety, otherwise delete the categories that do not apply.]

Certain types of health information require special permission. In order to conduct this research study the research team requires your special permission to obtain the protected health information listed below. By initialing below, you are specifically authorizing the research team to collect, use and disclose your protected health information pertaining to:

\_\_\_\_\_\_\_\_ Sexually Transmitted Disease

\_\_\_\_\_\_\_\_ Abortion

\_\_\_\_\_\_\_\_ AIDS or HIV

\_\_\_\_\_\_\_\_ Behavioral or Mental Health/Illness

\_\_\_\_\_\_\_\_ Drug or Alcohol Abuse, Diagnosis, or Treatment

1. By signing this form you authorize the research team to collect, use and disclose your protected health information as listed above, in relation to health care provided to you during the following time period: INSERT DATE RANGE.

[In accordance with the HIPAA Rules we must request/use/disclose the minimum amount of protected health information necessary to accomplish our intended purpose. As such, the research team must indicate the time period from which the PHI will be accessed/used/collected. Examples: “January 1, 2015 to present”; “last five years”; “from your initial diagnosis of breast cancer until the end of this research study”. “All” should only be included here if you determine that it is necessary for this research study to obtain the specific PHI for all time periods in which it exists.]

[If the research study itself will create PHI—e.g. when a member of the research team will be creating and then collecting protected health information from his own provision of healthcare to the participant during the course of the study—the research member(s) should be listed in Section B(1), and the research team should consider including this statement or similar statement here: “the duration of the research study” or the specific date range for the study if known.]

1. **How your protected health information will be used:** INSERT NAME OF PRINCIPAL INVESTIGATOR and his/her research team will collect, use and disclose the protected health information described in this form for the purpose of conducting the research study listed on this form. Generally, only INSERT NAME OF PRINCIPAL INVESTIGATOR and those individuals on the research team will see your protected health information. However, in certain circumstances the following individuals or organizations may have access to your protected health information:
2. The Department of Health and Human Services
3. The ETSU Institutional Review Board
4. The ETSU Human Research Protection Program
5. The ETSU HIPAA Compliance Office
6. Other representatives of ETSU as reasonably required to carry out the research study
7. The ETSU Research Corporation [must be included if a Research Corporation (formerly Foundation) study]
8. The Ballad Health HIPAA Compliance Office [must be included if using Ballad Health records]
9. Other representatives of Ballad Health as reasonably required to carry out the research study [must be included if using Ballad Health records]
10. The United States Food and Drug Administration
11. Individuals at East Tennessee State University that are responsible for financial oversight of research including billing and payments
12. The sponsor of this research: INSERT SPONSOR. “Sponsor” includes any persons or companies that are working with or for the sponsor, or owned by the sponsor.
13. Add
14. Add
15. Other Individuals/Organizations as required by law

[Delete those appearing in red if not applicable to this research study, and insert other individuals and/or organizations that may receive information as needed.]

1. **Access to your Protected Health Information:** During the course of this research study, you will not be allowed to see or copy your protected health information created by INSERT NAME OF RESEARCH MEMBER(S) CREATING PHI in connection with this research study. You will be allowed to see or copy these records at the conclusion of this study.

[This paragraph should only be included if protected health information will be created in connection to healthcare provided to the participant in connection to the research study. Otherwise it should be deleted in its entirety. Generally, the HIPAA Rules require us to allow patients to access their protected health information. However, the Rules anticipate this may not be practicable when such PHI is created in connection with a research study. This paragraph thus allows the research team to suspend the patient’s right of access for the duration of the research study.]

1. **Redisclosure of your protected health information:** Once your protected health information is disclosed to anyone outside this research study, the information may no longer be protected by the federal privacy standards and may be redisclosed without obtaining your authorization. INSERT NAME OF PRINCIPAL INVESTIGATOR and his/her research team will only collect, use and disclose your protected health information as described in this form or as otherwise permitted or required by law.
2. **Right to revoke this authorization**: If you sign this authorization form, you may change your mind at any time. If you change your mind, the research team may still keep and use your protected health information that they already have. The research team will not obtain any more protected health information about you for this research unless permitted or required by law after you change your mind.

In order to change your mind and revoke this authorization, you must send a written letter to:

INSERT CONTACT INFORMATION FOR PRINCIPAL INVESTIGATOR

If you change your mind you will no longer be able to participate in this research study.

1. **Expiration of authorization:** This authorization will INSERT EXPIRATION DATE.

[Be careful when choosing the date of expiration or expiring event if you decide to have a specific expiration. The expiration date refers to the date after which the research team will no longer be able to obtain protected health information or access patient records for research. The HIPAA Rules as they relate to research allow the research team to decide whether or not the HIPAA authorization will expire, but a statement of decision must be included. You should either state: This authorization will not expire; This authorization will expire INSERT DATE; This authorization will expire INSERT EXPIRING EVENT such as “at the end of this research study”.]

1. **Questions about Privacy:** If you have any questions or concerns about your privacy rights you may contact the East Tennessee State University HIPAA Compliance Office via telephone 423-439-8533 or mail P.O. Box 70285, Johnson City, TN 37614.

By signing below, I confirm that I am 18 years old or older and have read and understand both the Informed Consent and HIPAA Authorization sections of this form and that I had the opportunity to have them explained to me verbally. I confirm that I have had the opportunity to ask questions and that all my questions have been answered. By signing below, I confirm that I freely and voluntarily choose to take part in this research study, and that I authorize INSERT NAME OF PRINCIPAL INVESTIGATOR and his/her research team to collect, use and disclose my protected health information as described in this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant Date

Printed Name of Participant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of LAR Date

If signed by someone on behalf of the Participant, state your relationship to the Participant and a description of your authority to act on the Participant’s behalf: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Above Included only if being signed by a legally authorized representative (LAR)]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Obtaining Consent Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

[Signature of an Impartial Witness is necessary when the participant or their representative speaks and understands English, but cannot read and write; or when the participant or their representative is visually impaired and such impairment cannot be accommodated with increased font size.

Witness requirements: Impartial meaning the witness is not involved with the research study and is not unfairly influenced by people involved with the research study. The witness must be present for the consent process not just present for the signature. The witnessing is attesting that the informed consent process took place not as the veracity of the process nor the understanding of the Participant.]

***You will be provided with a copy of this signed consent and authorization form.***