**Consent form for use of materials**

**TITLE:** [*The full title of the project needs to be inserted here*]

The goal of the [project] is to [*explain why the research or the teaching is necessary by explaining the purposes*].

I have read the description above and understood all of the arrangements as well as the implications for the use of all the material collected. Based on the content of this form, I hereby give my free consent to be photographed [and videotaped if needed] and for [insert full name] to obtain information ahead from my clinical record [list all the information that will be extracted]. [if appropriate, explain why the use of images of my face or distinctive marks on my body should be published and adapt accordingly the 2nd bullet in the section below].

I have the right to refuse to sign this consent form without any repercussion on my current and future care.

I will not receive any payments for the use of the shared material now and in the future.

By signing this document:

* I accept that my photos [if appropriate, include subject(s) discussed] and the medical information on my health care experience identified above OR concerning a member of my family [remove information if not appropriate] can be published professionally [and declare that I am the parent or the legal guardian of the minor named above, and have the legal authority to sign this consent form in his/her name] or be used to build a case study in the future.
* I allow pictures of my face or distinctive marks on my body to be published, thus acknowledging that I could be identified even if my name or my initials aren’t published.
* I accept that the materials including the photo(s) [iand videos if appropriate] will be published in the [insert full name here XXX ], on the website [insert full name here XXX]. I therefore understand that the materials can be seen by the general public.
* I accept that some or all of the material that will be used to write my story (case study) can also be used with other photographies, drawings, video-clips and sound recordings.
* I understand that my name and my initials will not be used and that no personal information will be communicated or released without my explicit consent or outside of the context explained in the document unless required by law. All efforts will be used to hide your identity.
* I understand that I can revoke my consent any time before the publication. However, once the information has been submitted to publication, I can no longer revoke my consent.
* [other precisions].

The members of the study team will sign a confidentiality agreement form, meaning that they commit themselves not discuss or share my information with anybody, even with my health care team.

There are two copies of the consent form, one of which I can keep.

**Consent**

I, undersigned \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent that you can use the information gathered for the case study entitled : « [insert full title] ».I understand that at the exception of the title of the project, the journal and the website that will publish the case study, all the other identified requirements that I have signed in the consent form will be applied exactly like they were described, especially those who relate to the confidentiality and protection of my personal information.

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Signature of participant Date

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

Signature of parent or legal guardian Date

**Declaration of the person responsible to obtain the consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I have explained this form to the participant and answered any and all questions that she/he asked on the matter and have clearly identified that she/he can revoke their consent and withdraw, at any time, their participation to this study as described above. Thus, I will ensure that the objectives of this study will be pursued and the confidentiality respected.

Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , the \_\_\_\_\_\_\_\_\_\_\_\_\_201\_.

For information on the ethical aspects of this project, I can go to the Ethics Research Committee of the Montfort Hospital, 745-A Montreal Road, Ottawa, Ontario, by phone 613-746-4621 , extension 2221 or by email at ethique@montfort.on.ca.

In the event that the participant can not read the consent form (blind, etc.) or that it is not able to consent (children, cognitive disorders, etc.), it is necessary to add a space for the signature of a witness or an authorized third party. N.B. Do not include this section if this does not apply to your project. If necessary, refer TCPS2 for more details in Chapter 3, the consent process (p. 29-48).