

***CONSENT TO CONTACT TEMPLATE***

*Italicized text is instructional, providing information to the consent form writer. It should be deleted when writing the consent form. Unless otherwise indicated, the remainder of the text is mandatory.*

*Consistent with Section 34 of the Health Information Act, a custodian (such as a patient's clinician) may disclose individually identifying health information including contact information to a person other than the individual who is the subject of the information if the individual has consented to the disclosure.   This means that clinicians must seek patient consent to pass along their contact information to a research team.  This form can be used to document this consent.*

**CONSENT TO CONTACT FOR RESEARCH PURPOSES**

**TITLE:** *The full title of the research project goes here.*

**SPONSOR:** *Put the name of the organization/company providing funds, drugs and/or equipment here.*

# INVESTIGATORS: *State the name of the local Principal Investigator followed if desired by the names of any co-investigators (see note above).*

You are being invited to give consent for *[Principal Investigator’s name]*, or a qualified member of *[his/her]* study team to contact you at some time in the future to invite you to participate in a research study.

Are you willing to learn more about the *[study title]* study? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

***[Specify, e.g., Telephone]*:**

***[Specify, e.g., E-mail]*:**

You authorize your health service provider to disclose your *[specify which health information is being requested - e.g., name, telephone number, and email address]* to the research team for the purpose of being contacted to learn more about the research study, *[study title]*.

Every effort will be made to safeguard your contact information. Although access to this information will be limited, there is a small chance that this information could be inadvertently disclosed or inappropriately accessed.

You have been made aware of the reasons why the contact information is needed and the risks and benefits of consenting or refusing to consent.

This consent is effective immediately. *[If this consent includes an expiry date, specify it here].* Your consent to be contacted can be revoked by you at any time.

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**