

**Participant Consent to Release Information**

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| --- | --- |
| **Title** |  |
| **Short Title** |  |
| **Protocol Number** |  |
| **Project Sponsor** |  |
| **Coordinating Principal Investigator** |  |
| **Principal Investigator** |  |
| **HREC Reference** |  |
| **Location**  |  |

**Declaration by Patient**

1. I give permission for my personal contact information to be provided to the research team at (insert name here) for the purposes of potentially participating in the research study outlined above.
2. I agree to the provision of this information on the condition that if I am not accepted into the trial, the site will immediately destroy everything provided to it under this consent.
3. I understand that someone from the research study will contact me to discuss the study in further detail.

Should you have any complaints regarding the collection of this information for this study, please contact the Metro North Research Governance Manager.

Complaints contact person

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| --- | --- |
| Contact | Research Ethics and Governance Manager |
| PH: | 07 3647 9550 |
| E: | MetroNorthResearch-RGO@health.qld.gov.au |

Patient’s Name (please print) :

Patient’s Signature: Date: