**PART I: INFORMED CONSENT FOR CASE REPORTS**

**Case Report Title:**

**Principal Investigator** **/ Author:**

**Institution:**

**Contact Phone Number:**

1. **Introduction**

You are being invited to consider allowing Dr. **< NAME OF AUTHOR** > to use your clinical information and medical history about your (insert condition/disease/experience) to write what is called a case report.

A case report is a medical publication that describes a patient’s unique medical condition, treatment, or response to therapy. Case reports are typically used 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 presented at a conference and/or published (in print and/or via internet dissemination) for others to read. This form explains the purpose of this case report.

Please read this form carefully and take your time to make your decision and ask any questions that you may have.

1. **Purpose of the Case Report**

The purpose of this case report is to contribute to medical knowledge by sharing your experience so that doctors, researchers, and students may learn from it.

Your information being used for this case report includes (insert specific information here including use of pictures or radiographic images).

1. **Information to be Shared**

Your medical history, laboratory and diagnostic results, and treatment course may be included. Any photographs, images, or test results will not contain your name or other direct personal identifiers.

1. **Privacy & Confidentiality**
* Your personal data will be handled in compliance with the **Data Privacy Act of 2012 (Republic Act 10173)** and its Implementing Rules and Regulations.
* No personal identifiers (such as your name, address, or exact date of birth) will appear in the report.
* Efforts will be made to ensure your privacy. However, complete anonymity cannot be guaranteed, especially if your case is rare.
* Clinical images (if any) will be de-identified, but there remains a small chance that someone familiar with your condition may recognize you.
* Your records will be stored securely, accessible only to the research team, and destroyed after the retention period required by institutional policy.
* Dr. **< NAME OF AUTHOR** > is 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 be anonymized and not be disclosed.
1. **Voluntary Participation**Your consent is voluntary. You may withdraw your consent at any time before the case report is published, without any effect on your medical care.
2. **Risks and Benefits**
* There is no direct risk or direct medical benefit to you for participating.
* You will not directly benefit from participating in this case report.
* The benefit is primarily social: your case may help improve medical knowledge and patient care in the future.
1. **Compensation**
You will not receive any financial compensation for participating in this case report, as it does not involve additional procedures or costs beyond your standard medical care.
2. **Consent for Images (if applicable):**

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| --- |
|[ ]  I agree that clinical images (photographs, scans, or laboratory results, etc.) may be included in the case report, provided my identity is protected. |
|[ ]  I do not agree to the use of my images. |

1. **Consent for Publication**By signing this form, you consent to the use of your de-identified medical information, including clinical details, diagnostic results, and images, for publication in medical journals or presentations.
2. **Contact Information**

You are free to ask any questions that you may have about your participation. If you have any questions, please contact the Author of this case report:

Author:

Telephone No.:

Email address:

If you have any questions about your rights as a participant in this case report, you may contact:

**DR. JOSEPHINE M. LUMITAO**

Chairman

UST Hospital - Research Ethics Committee

6/F St. John Macias O.P. Building (formerly Clinical Division Building) UST Hospital

Telephone/Email address: 8731-3001 local 2610 / **usthrec@gmail.com**

**PART II: CERTIFICATE OF CONSENT TO PARTICIPATE**

**Case Report Title:**

By signing this form, I confirm that:

|  |
| --- |
|[ ]  I have read and I understand the informed consent the case report has been fully explained to me and all of my questions have been answered to my satisfaction |
|[ ]  I have been informed of the risks and benefits, if any, of allowing my information to be used in this case report |
|[ ]  I have been informed that I can refuse or withdraw my consent at anytime |
|[ ]  I authorize access to my personal health information (medical record) as explained in this form |
|[ ]  I freely agree to participate in this case report and use my medical records for the purpose explained to me. |
|[ ]  I understand that the case report will be published without my name attached and researchers will make every attempt to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed. |
|[ ]  I have been given a copy of the Participant Information Sheet and Consent Form to keep |

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Patient / Participant / Legally acceptable representative Date

Signature over printed name

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Person obtaining the consent / Author Date

Signature over printed name

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Witness Date

Signature over printed name