Retrospective Medical Record Review Consent Form

Study Title:

Principal Investigator:

Institution:

Introduction

You are being asked to allow access to your medical records for the purpose of a research study. Please read this form carefully and ask any questions you may have before agreeing to participate.

Purpose of the Study

Procedures

Confidentiality

Voluntary Participation

Participation in this review is voluntary. You may choose not to have your records included and can withdraw your consent at any time without penalty.

Contact Information

If you have questions about this study, please contact:
Investigator Name:
Phone:
Email:

Consent Statement

By signing this form, you agree to allow the use of your medical records for this research study.

Participant Name

Signature

Date