The Guthrie Clinic

One Guthrie Square
Sayre, PA 18840

Informed Consent Form

Study Title: {Study Title}

Study Doctor: {Principal Investigator name }

Study Site:

Guthrie Medical Group, P.C.	Robert Packer Hospital
One Guthrie Square	One Guthrie Square
Sayre, PA 18840	Sayre, PA 18840

Telephone numbers: Guthrie Clinical Research 570-887-6072 or 1-800-836-0388

Key Information

You are being asked for your consent to take part in a research study.

- Someone will explain this research to you.
- Taking part in this research is voluntary. Whether you take part is up to you.
- Ask all the questions you want before you decide.

The purpose of this research is to study {describe purpose of the study in layman's terms}. Your participation will last {enter duration of subject}. The details of the study are described below.

This research is not part of your medical care. The research is voluntary. You do not have to take part if you do not want to. Your medical care will not be affected if you decide not to take part. If you decide not to take part, there will be no penalty to you, and you will not lose any of your regular benefits.

Research Study

We would like to invite you to join a research study. This reseach study is {briefly describe overview of study in layman's terms}.

The Guthrie Clinic is providing financial support for this study.

About {anticipated number} people will take part in this study.

Procedures

If you decide to take part in this research study, you will {describe procedures}. {List procedures that are experimental} are experimental.

You are expected to be in the study for {expected duration of subject's participation}.

If you decide not to join this study, you may discuss other options with your study doctor. If you enter the study and then change your mind, you will be free to leave the study, and there will be no change in how you will be treated. The study doctor may stop you from taking part in this study at any time if he or she believes it is in your best interest or if the study is stopped.

Risks

Care will be taken to minimize the risks of taking part in this study. Risks of taking part include: {Describe risks of study in layman's terms}. There may be risks that are not yet known.

Benefits

Taking part in this study may give your doctor information about your medical condition. {Describe benefits}. This information may be useful in evaluating any further treatment you may need, but we cannot guarantee it. Taking part in this study may lead to knowledge that will help others.

Costs

There are no costs for taking part in this study. You or your insurance provider will be charged in the standard manner for any services that are part of routine care.

If you are hurt or injured from being in the study, The Guthrie Clinic has no program to pay you or provide you with any other compensation for the injury. Medical care at The Guthrie Clinic is open to you as it is to all sick or injured people. You do not give up any of your legal rights by signing this form.

Confidentiality

Information about you will be treated in strict confidence to the extent required by law. Information in your medical records that could identify you will not be shared with anyone outside of The Guthrie Clinic.

Representatives from the Institutional Review Board of The Guthrie Clinic (a group of people who review the research to protect the rights of participants), The Guthrie Clinic Administration and federal regulatory agencies may inspect research records that could reveal your identity. These persons are bound by confidentiality regulations.

Your private information collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

Authorization (Permission) to use your health information for research purposes

By signing this form, you are agreeing to permit the study doctor and his/her colleagues at The Guthrie Clinic to review information in your medical records to conduct this research study.

This permission allowing use of information in your medical records for this research does not expire.

Withdrawing permission

You have the right to withdraw the permission at any time, and no additional efforts to collect individually identifiable health information about you will be made. However, health information acquired using this permission prior to its withdrawal may continue to be used to the extent that the investigators have already relied on your permission to conduct the research. If you chose to withdraw this permission, please notify the investigator in writing.

Not signing this consent form and permission will not affect the present or future care you receive at The Guthrie Clinic and will not cause any penalty or loss of benefits to which you are otherwise entitled.

Further Information about this study

You can talk to your study doctor about any questions or concerns you have about this study or if you feel you have had a research-related injury. Contact your study doctor at the numbers provided on the first page of this consent form.

A description of this clinical trial may be available on http://www.Clinicaltrials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

Other questions, concerns or complaints

If you have questions about your rights while taking part in this study or afterwards, or any concerns or complaints about how the research is being conducted, please call the Institutional Review Board of The Guthrie Clinic at (570) 887-4885 or leave a message at **www.guthrie.org/irb** This website also contains links to federal regulations on the protection of human research participants.

You will receive a copy of this form.

Research Subject

By signing below, I certify that I have read or had read to me and understand this consent form. I have had an opportunity to ask the doctor all my questions concerning the research study, the risks, benefits, alternatives, and risks of those alternatives. I consent to participate in the research described in this form, and I authorize the use and disclosure of Protected Health Information as described in this form.

_____ _____ Date: __/__/___ Time: _____

Printed Name of Subject | Signature of Subject or Legally Authorized Representative

_____ _____

Printed Name of Legally Authorized Representative | Relation to Subject

Witness (Guthrie Employee)

☐Yes ☐ No The patient/authorized representative has read this form or had it read to him/her.
☐Yes ☐ No The patient/authorized representative expresses understanding of this form.
☐Yes ☐ No The patient/authorized representative has no further questions.

_____ _____ Date: __/___/___ Time: _____

Printed Name of Witness | Signature of Witness

Person Obtaining Consent

I hereby certify that the risks, benefits, alternatives, and risks of those alternatives of this study in this consent form have been discussed with the individual granting consent. It is my opinion that the person signing this consent form understands and comprehends all of the matters discussed.

_____ _____ Date: __/__/___ Time: _____

Printed Name of Person Obtaining Consent | Signature of Person Obtaining Consent

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Impartial Witness **(when applicable)**

If the consent form is read to the subject or legally authorized representative because the subject or legally authorized representative is unable to read the form, an impartial witness not affiliated with the research or investigator must be present for the consent and sign the following statement.

I confirm that the information in the consent form and any other written information was read to, accurately explained to, and apparently understood by the subject. The subject freely consented to be in the research study. I confirm that I was present during the entire informed consent discussion.

_____ _____ Date: __/__/___ Time: _____

Printed Name of Impartial Witness | Signature of Impartial Witness