

## AUTHORIZATION TO STORE HEALTH AND CONTACT INFORMATION

Medical research is very important as it leads to the discovery of new treatments that may benefit all Canadians. Research also allows you to take part in the newest medical treatments and experience the best medical care. By law, researchers must protect the privacy of health information about you. This form describes what we will do with your information. Please read it carefully. If you agree, please sign your name at the bottom. You will get a copy of this form once you have signed it.

If you sign this form, the contact and health information you enter below will be kept in our confidential research database. This information will not be shared with any other organizations. Entralogix will use your information to contact you if a compatible clinical trial arises. At such point, an Entralogix research nurse will contact you, inform you about the study and it will be your choice as to whether you want more information. Read below for further clarification.

**1. What "health information" includes:**

Information you enter below in section 6 and 7.

**2. What Entralogix will do with your health information?:**

Entralogix will use the health information about you to see if you might qualify for a research study. If you qualify, a staff member may contact you and notify you of the study.

**3. Storing your health information:**

Your health information will be added to a confidential database or data repository. This permission will end when the database or data repository is destroyed.

**4. Please note:**

You do not have to sign this permission ("authorization") form. If you do not, we will not add you to the patient research database. You may change your mind and take back your permission at any time. To take back your permission, write to [Entralogix Clinical Group Inc.](#)

**6. Your signature:**

I agree to the use of my health information for the purposes described above.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Patient

**7. Contact Information**

Street		Gender (circle)	M	F
City/Province		Date of Birth:		
Postal Code		Home Phone:		
Family Physician:		Work Phone:		
		Cell Phone:		
Specialist:		E-mail:		
Health Information:				