BARCODE HERE

SMR000000

Health
South Eastern Sydney
Local Health District

NSW GOVERNMENT

Facility:

Health Science Alliance Biobank Consent

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Consent for HSA BIOBANK

- I _____agree to participate in the HSA Biobank described in the patient information brochure provided.
  Or (*if applicable*)

  I _____as guardian/power of attorney for _____agree for their participation in the HSA Biobank described in the patient information brochure provided.
- I have read the patient information brochure or have had read to me in my first language, and I understand it.
- I have been given the opportunity to ask any questions and I have received satisfactory answers.
- I understand that I can withdraw consent at any time without affecting any medical treatment or care now or in the future.
- I agree that research data gathered from the results of the HSA Biobank may be published, provided that I cannot be identified.
- I understand that if I have any questions relating to my participation I can contact the HSA Biobank directly using the contact details provided in the patient information brochure.
- I acknowledge receipt of a copy of the patient information brochure for my own records.

Please read carefully and tick either YES or NO

1. I give my permission for the collection of tissue/fluid and blood/saliva samples and their use in future research — Yes ☐ No ☐
2. I give my permission for the collection of clinical hospital data, the linkage of data from other sources and its use in future research — Yes ☐ No ☐
3. I give permission for the Department of Human Services to provide my/the participant's Medicare and/or Pharmaceutical Benefits Scheme (PBS) claims history for the period 1/11/2009 to 31/12/2033 for the HSA Biobank Study — Yes ☐ No ☐

Medicare Card Number _____

- A copy of this consent form will be sent to Department of Human Services
- Additional information about Medicare/PBS claims history will be provided to you, or can be found on the HSA Biobank website.

_____	_____	_____
PARTICIPANT PRINT NAME	SIGNATURE	Date
_____	_____	_____
GUARDIAN/POWER OF ATTORNEY NAME (*if applicable*)	SIGNATURE	Date

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

XXX0000 – 00/0000

Health Science Alliance Biobank Consent

FORM #