Health Science Alliance Biobank Consent

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 __________