

PARTICIPANT CONSENT FORM

Consent to release of Medicare Benefits Schedule (MBS) and/or Pharmaceutical Benefits Scheme (PBS) claims information by Services Australia to - HDQ + D L O H V I R U : R P H O T P P o s e s b D I O W a c
Clinical and Scientific Trials (NECST) Network Registry Study

Important Information (This form is only to be used for participants over 14 years of age)

Complete this form to request the release of your personal Medicare claims information and/or your PBS claims to the NECST Network Registry Study. Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with your information.

Rights and Privacy:

I understand that:

F my MBS and/or PBS information will be disclosed by Services Australia for the purposes of the study.

F the results of this research may be published in articles or journals.

F my name will never be disclosed by Services Australia, used in the study or published.

F my participation in the study is completely voluntary.

F I can withdraw my participation in the study at any time (refer to participant information sheet and withdrawal of consent form) and I do not have to provide a reason for my withdrawal

information on this form is true and correct.

6. Signed by _____ (full name) _____ (signature) on behalf of participant

DD / MM / YYYY

Dated: ___ / ___ / ___

March 2020

Legal guardian**

Power of attorney**

Guardianship order**

** Please attach supporting evidence (Power of Attorney)

Power of attorney