Consent to Participate in Research

***Select*** *appropriate Study sites*

The University of Texas Southwestern Medical Center

Parkland Health & Hospital System

Children’s Medical Center of Dallas and any of its affiliated entities

Retina Foundation of the Southwest

Texas Scottish Rite Hospital for Children

Texas Health Resources

You are being asked to participate in a research study.

Before you agree, the investigator must tell you about (i) the purposes, procedures, and duration of the research; (ii) any procedures which are experimental; (iii) any reasonably foreseeable risks, discomforts, and benefits of the research; (iv) any potentially beneficial alternative procedures or treatments; and (v) how confidentiality will be maintained.

Where applicable, the investigator must also tell you about (i) any available compensation or medical treatment if injury occurs; (ii) the possibility of unforeseeable risks; (iii) circumstances when the investigator may halt your participation; (iv) any added costs to you; (v) what happens if you decide to stop participating; (vi) when you will be told about new findings which may affect your willingness to participate; and (vii) how many people will be in the study.

If you agree to participate, you must be given a signed copy of this document and a written summary of the research.

You may contact (**name**) at (**phone number**) any time you have questions about the research.

You may contact University of Texas Southwestern Medical Center Human Research Protection Program (HRPP) at 214-648-3060 if you have questions about your rights as a research subject or what to do if you are injured.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

|  |
| --- |
| Signing this document means that the research study, including the above information, has been described to you orally, and that you voluntarily agree to participate. |
|  |  |  |  |  |  | AMPM |
| Printed Name of Participant |  | Signature of Participant |  | Date |  | Time |
|  |  |  |  |  | AMPM |
| Printed Name of Parent/guardian (children <18) |  | Signature of Parent/guardian (children <18) |  | Date |  | Time |
|  |  |  |  |  |  |  |
|  |  |  |  |  | AMPM |
| Printed Name of Witness/Interpreter |  | Signature of Witness/Interpreter  |  | Date |  | Time |

**Note: If HIPAA applies: Request an "Alteration of HIPAA Authorization" – Form H:**
This should be provided in the "HIPAA" section using Form H. The alteration means that when using the Short Form Consent Process, neither the participant nor their LAR should sign the HIPAA Authorization (whether there is a separate HIPAA Authorization or one embedded in the Summary Form (the modified English consent form).