PATIENT CONSENT FORM

Date:_____

Patient/Guardian Name: OP ID/Hospital ID:

I hereby consent for the observational studies to be made of me or for the person whom I am legal guardian to collect the blood sample. I understand that the information may be used in my medical record for research purposes, for publications in journals as I designated below. By consenting to this clinical blood sample, I will not receive any payment from any party. Refusal in consent to collect the blood sample will no way affect the medical care I receive.

By signing this form below, I confirm that this consent form has been explained to me in terms that I understand.

Patient/Guardian Signature: Address with Contact Number: