**Consent to Publish Information**

1. I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to Island Health (Vancouver Island Health Authority) to release my information, as listed in point 6 below, to Dr. <name> in order for them to a publish medical article related to <description> I experienced on [insert date], 20XX. I understand that this information will be published in a medical journal available publically (inside and outside of Canada) and to the medical professions for the purpose of advancing global knowledge on this condition and in order to prevent future delays in recognition of the condition that may result in unnecessary treatment. <please revise as appropriate for your study>

1. I fully acknowledge and understand that while information that is directly linked to me (such as name or other personal identifiers) will not be published, that people may be able to re-identify me by linking some of the information which is unique to me in the article (such as my age, my condition and background information) with other sources of information and, as such, my confidentiality cannot be guaranteed.
2. I fully acknowledge and understand that my consent to this release and publication is fully voluntary and that if I do not consent, it will not negatively impact my current or future care in any way.
3. I fully acknowledge and understand that I may revoke this consent; however, in the event that an article has already been submitted for publication that said consent cannot be revoked for that specific article.
4. I fully acknowledge and understand that any further questions I may have regarding this form or my consent may be directed to Dr. <name> at [insert phone number].
5. I fully understand and hereby give my free consent to Dr. <name> to obtain information from my clinical record. This may include the following types of information will be published:
* Brief background on the event
* Age
* Gender
* Admitting diagnosis
* The reaction I experienced
* Steps taken to manage the reaction <amend list as appropriate>
* Photographs, drawings, video-clips and/or sound recordings. (if applicable: I allow pictures of my face or distinctive marks on my body to be published, thus acknowledging that I could be identified even if my name or my initials aren’t published.)
1. I acknowledge I have received a copy of this consent form and have received additional explanation so as to constitute informed consent, and hereby permit and consent to the above, effective on the date signed below and until such time as I withdraw consent.

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 Client Name (Print) (Client Signature) Date

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 Physician Name (Print) (Physician Signature) Date