

CPMC INSTITUTIONAL REVIEW BOARD

2200 Webster Street, 5th Floor,
SF CA 94115

Phone #: 415.600.3688

FAX #: 415.600.1753

PI Name:

PI Address:

PI Phone #:

Title of Study:

Dear:

I want to end my participation in the research study above. I was told that the research team will continue using health information already collected. However, they will only use the information for reasons discussed in the consent form and authorization I signed when I joined the study.

In addition to ending participation, I would like to (please choose one of the following options):

**REVOKE MY CONSENT TO PARTICIPATE IN RESEARCH AND
AUTHORIZATION TO USE INFORMATION.**

NOTE: You chose not to participate in the study and the research team will not collect any more information about you. *In rare cases, the research team may need to use your information even after you revoke your authorization, for example, to let you know about any safety concerns.*

**WITHDRAW MY CONSENT TO PARTICIPATE IN RESEARCH, BUT
CONTINUE MY AUTHORIZATION TO USE INFORMATION.**

NOTE: You chose not to actively participate in the study, but you are not withdrawing your authorization for the research team to continue to use information from your medical record *as needed for the study in conformance with the authorization form that you originally signed.*

Name/Signature of Participant Date