

CPMC INSTITUTIONAL REVIEW BOARD
2200 Webster Street, 5th Floor, SF CA 94115
Phone #: 415.600.3688
FAX #: 415.600.1753
EMAIL: reviewbd@cooper.cpmc.org

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