Rady Children's Hospital San Diego
3020 Children's Way
San Diego, CA 92123

Rady Children's Specialists of San Diego
A Medical Foundation

DTF1322

Use of Specimens Consent Form

PLACE PATIENT ID LABEL INSIDE BOX

By signing this form, I understand that:

(a) tissue, fluids, cells and other specimens not required for your diagnosis or treatment (collectively "Specimens" that Rady Children's Hospital-San Diego, Rady Children's Specialists of San Diego, and/or Children's Primary Care Medical Group, Inc. may collect during the course of treatment may be used by and shared with researchers, in accordance with state and federal law, including all privacy laws; and
(b) under California law, patients do not have any rights in Specimens or rights to any commercially useful products that may be developed through research using Specimens.

I understand that after signing this Agreement, I cannot later prohibit use of Specimens that have already been shared. However, I can prevent future sharing of Specimens by making a written request to RCHSD.

My consent choices are outlined as follows:

My Consent Choices (CHECKONE):

☐ I GIVE MY CONSENT FOR Rady Children's Hospital – San Diego, Rady Children's Specialists of San Diego, and Children's Primary Care Medical Group, Inc. to use and share with researchers any Specimens collected during the course of treatment.

☐ I DENY CONSENT FOR Rady Children's Hospital – San Diego, Rady Children's Specialists of San Diego, and Children's Primary Care Medical Group, Inc. to use and share with researchers any Specimens collected during the course of treatment.

Signature of Patient or Authorized Representative:
If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Signature of Patient or Authorized Representative | Time | Date

If signed by someone other than the patient, print name and indicate relationship:

_____ _____
Printed name of Authorized Representative | Relationship

Address of Authorized Representative signing this form (please print):

_____ _____ _____ _____
Street address/PO Box | City | State | Zip Code

Phone number of Authorized Representative signing this form: _____
XXX – XXX – XXXX

Signature of witness:
A Witness is required ONLY for telephone consent, physical inability to sign, or signature by mark. Telephone consent is subject to verification of identity.

_____ _____ _____ _____
Witness | Relationship | Time | Date