

PATIENT CONSENT FORM:

I, the undersigned.....(full name)

adult male / female from(address)

Id No..... hereby authorise Doctor

who is in possession of information concerning my health and personal particulars to disclose such information to the Chronic Pancreatitis Register as administered by the Hepato-Pancreatico – Biliary Association of South Africa. I further understand that this information will be depersonalised for reporting purposes and that it may only be used for the purposes of health research and /or studies.

I further wish to indicate that such permission to disclose such information is only for the purpose of health research and/ or study with a view of improving the management of Chronic Pancreatitis to the benefit of patient outcomes.

I further wish to indicate that this consent was given out of my own free will without any undue influence from(name of doctor).

Thus signed aton this day of2009

.....

Signature of patient

.....

Witness