CONSENT FORM

I, ____, hereby provide consent to be contacted to provide information regarding participation in the clinical trials. I understand that this consent is voluntary, and my decision will not affect my current or future medical care.

Preferred Method of Contact: (Check one)

- Phone____
- Email____

DISCLOSURE. I understand that by providing this consent, I may be contacted to discuss my potential participation in the clinical trial. I have been informed about the purpose, procedures, potential risks, and benefits of the study. I am aware that I can withdraw this consent at any time without any impact on my medical care.

Consentee's Signature: ________________________ Date: _____________

Print Name: ________________________