

Authorization to Contact Patients for Research Studies

[Place Label Here]	Preferred Method of Contact:	Today's Date: / /	
	<input type="checkbox"/> E-mail	Phone number: () <input type="checkbox"/> This is a cell phone	
	<input type="checkbox"/> Phone <input type="checkbox"/> Mail		
	E-mail Address:		
Address:			
City:		State:	Zip Code:

Callen-Lorde Community Health Center provides comprehensive and affirming care to LGBTQ communities and people living with HIV regardless of their ability to pay. To better serve our patients, Callen-Lorde Community Health Center regularly conducts research studies on health care, health disparities and potential health interventions. Some of these studies are paid while others are not. By signing this form, if indicated below, you give consent for Callen-Lorde Community Health Center to contact you about research studies that you may be eligible for via phone or e-mail. Signing this form does not enroll you in any study and you can withdraw your consent to be contacted at any time.

**The choice I make in this form will NOT affect my ability to get health care services at Callen-Lorde Community Health Center.
I know that I will only be contacted if I may be eligible for a study.**

My Consent Choice. ONE box is checked to the left of my choice.

I can fill out this form now or in the future.

I can also change my decision at any time by completing a new form

I GIVE CONSENT for Callen-Lorde Community Health Center to contact me via phone or e-mail about research studies.

I DENY CONSENT for Callen-Lorde Community Health Center to contact me about research studies.

By signing this form, I understand that Callen-Lorde Community Health Center may or may not contact me based on the above indicated consent choice regarding research studies I may be eligible for.

<i>Signature of Patient or Patient's Legal Representative</i>		<i>Date</i>
<i>Print Name of Legal Representative (if applicable)</i>	<i>Relationship of Legal Representative (if applicable)</i>	