Richmond Pharmacology Limited	RICHMOND Pharmacology

VOLUNTEER CONSENT FORM

PATIENT NAME:

DATE OF BIRTH:

GENDER:

RPL ID:

RPL STUDY:

I hereby give my permission for Richmond Pharmacology to contact my General Practitioner and/or specialist involved in my care in order to request medical information to determine my suitability to participate in a clinical trial.

I understand that this medical information is valid for six months only and as such, by signing this form, Richmond Pharmacology may re-contact my General Practitioner and/or specialist involved in my care every time the information they provide expires.

MEDICAL PRACTITIONER CONTACT DETAILS: (your doctor's details)

IF THIS IS YOUR GP THEY MUST HOLD AT LEAST 6 MONTHS MEDICAL HISTORY ON YOU

NAME:

ADDRESS:

TELEPHONE:

FAX:

VOLUNTEER SIGNATURE:

DATE SIGNED:

All information given by your Medical Practitioner will be treated in strict confidence.