11. Consent Form 1

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project, as described.

I give my permission for my doctors, other health professionals, and laboratories to release information to Melbourne Sexual Health Centre about consultations or tests I have had done as a result of my anal examinations. I understand that such information will remain confidential.

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) ……

Signature Date

Declaration by researcher: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) ……

Signature Date

Note: All parties signing the consent section must date their own signature.

Participant ID:

PARTICIPANT CONSENT FORM 2

Consent to release of Medicare and/or Pharmaceutical Benefits Scheme (PBS) claims information for the purposes of ACE Study: A trial of annual anal examinations (AAE) to detect early anal cancer in HIV positive men who have sex with men

Important Information

Complete this form to request the release of personal Medicare claims information and/or PBS claims information to the ACE Study.

Any changes to this form must be initialled by the signatory. Incomplete forms may result in the study not being provided with your information.

By signing this form, I acknowledge that I have been fully informed and have been provided with information about this study. I have been given an opportunity to ask questions and understand the possibilities of disclosures of my personal information.

PARTICIPANT DETAILS

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name: _____ First given name: _____

Other given name (s): _____

Date of birth: DD/MM/YYYY

2. Medicare card number: _____

3. Permanent address: _____

Postal address (if different to above): _____

AUTHORISATION

4. I authorise the Department of Human Services to provide my:

☐ Medicare claims history OR

☐ PBS claims history OR

☐ Medicare & PBS claims history

for the period / / to: / / to the ACE Study.

DECLARATION

I declare that the information on this form is true and correct.

5. Signed: _____ (participant's signature) Dated: __/__/____ **OR**

6. Signed by _____(full name) _____ (signature) on behalf of participant

Dated: : __/__/____

☐ Parent (where the participant is under the age of 14 years old*)

☐ Legal guardian** (where the participant is under the age of 14 years old*)

☐ Power of attorney** ☐ Guardianship order**