	INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY (HFH IRB form rev: 6/6/2019)	DATE: 9/17/2024 MRN: 12345678 NAME: PATIENT NAME
<p align="center">APPROVED</p> <p align="center">Jun 16, 2022</p> <p align="center">INSTITUTIONAL REVIEW BOARD</p>		PROJECT TITLE: Genetics of Hidradenitis Suppurativa

DOCUMENTATION OF CONSENT

By signing this form, I agree that I have read and understand this form and that I agree to participate in the research project described above. I have been given enough time and opportunity to ask about the details of the research study and to decide whether or not to participate. Its general purposes, the particulars of my involvement and possible risks and inconveniences have been explained to my satisfaction. I understand that I can withdraw at any time without giving any reason without my medical care or legal rights being affected. My signature also indicates that I have received a copy of this consent form.

The researchers in this study might want to ask you to participate in additional studies. In some cases, you might be a good candidate for a particular study because of your health history or genetic information.

I am willing to be contacted for future research studies. Please initial below.


AB I agree
 _____ I refuse

I understand that my de-identified genetic information may be placed in a repository and shared with other researchers for future research. Please initial below.

AB I agree
 _____ I refuse

I understand that the investigator may use publicly available databases to determine whether I am living, for purposes related to my participation in this study only. Please initial below.

ab I agree
 _____ I refuse

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[Signature]

Signature of Subject

9/17/2024

Date

12:10

Time

[Signature]

Printed Name of Subject

9-17-2024

Date

1:04

Time

[Signature]

Witness to Signature

Sept 17 2024

Date

4:02

Time

[Signature]

Signature of Person Obtaining Consent

John Smith

Printed Name of Person Obtaining Consent