Jefferson
University Physicians

Department of Dermatology
and Cutaneous Biology
Jefferson Dermatology Associates

T 215.955.6680 F 215.503.3333

Dear Patient,

We are soliciting your participation in studies on Pityriasis Rubra Pilaris (PRP). Enclosed you will find the latest version of the Pityriasis Rubra Pilaris (PRP) study packet. Please take your time to complete all questions and fill out all pages of the consent form (note: two signature pages). Answers will be analyzed as combined, anonymous data (along with those from other study patients). Your name will not be associated with any published information.

Of note, there are two Goals to this study: Goal 1 is genetic analysis to identify genes and pathways involved in PRP; Goal 2 is clinical data analysis to improve diagnosis and management of the disease. We prefer your participation in BOTH Goals; however, you may enroll in any.

Two forms must be completed for enrollment.
The first form is a consent document requesting your permission to participate in the study. The second signature page is a release of medical records document to permit a member of our research team to acquire clinical records from your physician(s). These documents will be kept confidential.

The second form is survey regarding PRP symptoms and treatments. Our research team will study these in order to describe the variety of PRP presentations, associated symptoms and treatments tried. Your protected health information will be kept confidential.

Please return ALL PAGES of EACH FORM to:

Email (PREFERRED), email subject line: "New PRP Enrollment"
PRP@jefferson.edu

Regular Mail
PRP Study, Attn: Nick Ross, MD
Department of Dermatology and Cutaneous Biology,
Thomas Jefferson University Hospital, Attn: Nick Ross,
833 Chestnut Street, Suite 740, Philadelphia, PA 19107, USA

HIPAA-compliant Fax Machine: (215) 503-3333

Do not hesitate to contact a member of the research team with any questions. Your participation is most helpful. We thank you for your time and commitment to the advancement of science and PRP diagnosis and treatment.

Sincerely,

Jouni Uitto, MD, PhD
Professor and Chair
Department of Dermatology
and Cutaneous Biology
Thomas Jefferson University
Philadelphia, PA 19107

Nicholas Ross, MD
Co-Investigator and Resident Physician
Department of Dermatology
and Cutaneous Biology
Thomas Jefferson University
Philadelphia, PA 19107

Department of Dermatology & Cutaneous Biology
Thomas Jefferson University Hospital

PITYRIASIS RUBRA PILARIS (PRP) PATIENT HISTORY

Your answers to this IRB Approved Survey will be kept strictly confidential. Data will be anonymously pooled and your name will not be associated with published findings, as outlined in the consent form.

Your DOCTOR(S)' Name (who diagnosed your PRP): _____

DOCTOR'S Telephone Number (who diagnosed your PRP): _____

PATIENT Name: _____ DATE OF BIRTH: ____/____/_____ (mm/dd/yyyy)

PATIENT Mailing Address: _____

_____

PATIENT Telephone: _____

PATIENT EMAIL: _____@_____

GENDER: ☐ Male ☐ Female

RACE/ETHNICITY: _____

Current HEIGHT: _____(cm) or (in) Current WEIGHT: _____(kg) or (lbs)

Age AT ONSET of Symptoms: _____ (years) Age AT DIAGNOSIS of PRP: _____(years)

What, if any, do you/your doctor believe "TRIGGERED" your PRP? _____

_____

_____

Was PRP CORRECTLY DIAGNOSED at the beginning?

☐ Yes

☐ No; If NO, how long did it take to identify the correct diagnosis? _____(months) ____(years)
If NO, what was the INITIAL DIAGNOSIS? _____

CONTINUED→

SKIN FINDINGS (please *check all* that apply):

☐ Red-Orange Plaques

Where did these start: _____

At its worst, location(s) with red-orange plaques: _____

_____

☐ Intervening/Normal skin "islands" in between areas of red rash

☐ Flaking of skin (fine scales)

☐ Waxy, red-orange thickening of palms and soles

☐ Redness/flaking around hair follicles/openings (scalp or body hair)

☐ Hair loss/thinning

☐ Eczema-like skin changes (dry, red, cracked); where: _____

☐ Nail Changes: ☐ thickened; ☐ yellow; ☐ deformed; ☐ buildup under nails; other: _____

☐ ONLY Elbows/Knees with thick, yellow-red-orange plaques/flaking of skin

☐ Lower legs (around shins) with larger, rectangular/rhomboidal scales of dry skin/cracking

SKIN BIOPSY (a sample of your skin taken/removed by a healthcare provider to examine further):

☐ NOT DONE

☐ DONE

If YES, BIOPSY DATE(S): ____/____/_____; ____/____/_____; ____/____/_____

If YES, was Pityriasis Rubra Pilaris (PRP) CONFIRMED BY SKIN BIOPSY?

☐ Yes

☐ No

PLEASE SUBMIT A COPY OF THE(SE) SKIN BIOPSY REPORT

Do you STILL HAVE SKIN FINDINGS/SYMPTOMS?

☐ Yes; If YES: TOTAL TIME, since onset, with skin FINDINGS/SYMPTOMS? _____(years)

☐ No; If NO: TOTAL TIME with skin FINDINGS/SYMPTOMS? _____(years)

What TYPE OF PRP Did Your Doctor Diagnose?

☐ Don't Know

☐ Classic Adult, Type I: Red-orange plaques with islands of normal skin, rough bumps around hair follicles and waxy, red-orange thickened skin on palms and soles.

☐ Atypical Adult, Type II: Areas of eczema-like skin irritation, irregular, thick brown scales on lower legs, thickened skin on palms and soles, hair thinning.

☐ Circumscribed Juvenile, Type III: Pre-pubertal onset involving only elbows and knees with skin thickening, scaling and redness.

☐ Classic Juvenile, Type IV: Onset within first 2 years of life, same appearance as Type I (red-orange plaques with islands of normal skin, rough bumps around hair follicles and waxy, red-orange thickened skin on palms and soles).

☐ Atypical Juvenile, Type VI: onset within the first few years of life, red bumps around hair follicles, tightened skin of the hands and feet, genetic link (often others in the family with PRP).

Is there a FAMILY HISTORY of PRP or Psoriasis?

☐ Yes; If YES, WHO has it?_____ AND is it PRP or PSORIASIS?_____

☐ No

TREATMENTS TRIED for PRP

☐ NONE

CONTINUED→

TOPICAL TREATMENT (please *check all* treatments tried) || **Was it helpful?**

☐ **Moisturizers**: type: _____; start __/__/___ stop __/__/____.....||....☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Topical Steroids**: name/strength:_____; start __/__/___ stop __/__/____||....☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Urea Cream**: name/strength:_____; start __/__/___ stop __/__/____.||...☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Salicylic Acid**: name/strength:_____; start __/__/___ stop __/__/____.....||...☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Retinoids** (Topical): name/strength:_____; start __/__/___ stop __/__/____.||..☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Calcipotriene/Calcipotriol**: start __/__/___ stop __/__/____.....||..☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Pimecrolimus/Tacrolimus**: start __/__/___ stop __/__/____.....||..☐ **Yes** ☐ **No**

☐ **Other**:name/strength:_____ start __/__/___ stop __/__/____.....||..☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **Other**:name/strength:_____ start __/__/___ stop __/__/____.....||..☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

SYSTEMIC TREATMENT (please *check all* treatment tried) || **Was it helpful?**

☐ **Retinoid (oral)**:name/dose/schedule: _____start __/__/___ stop __/__/____||☐ **Yes** ☐ **No**

Retinoid examples: acitretin, etretinate, isotretinoin, others

If yes, what symptoms improved/over how many months?_____

☐ **Methotrexate**: name/dose/schedule:_____; start __/__/___ stop __/__/____.....||.☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months?_____

☐ **TNF-α Inhib**: name/dose/schedule_____start __/__/___ stop __/__/____||☐ **Yes** ☐ **No**

TNF-α Inhib Examples: adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), golimumab (Simponi), certolizumab pegol (Cimzia)

If yes, what symptoms improved/over how many months? _____

☐ **IL12/23 Inhib**: name/dose/schedule_____start __/__/___ stop __/__/____..||..☐ **Yes** ☐ **No**

IL12/23 Inhib Example: ustekinumab (Stelara)

If yes, what symptoms improved/over how many monhs?_____

☐ **Light Therapy**: type/strength/schedule_____start __/__/___ stop __/__/___.||☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months? _____

☐ **Other**:name/strength_____start __/__/___ stop __/__/____.....||..☐ **Yes** ☐ **No**

If yes, what symptoms improved/over how many months? _____

CONTINUED→

MEDICAL HISTORY: (please *check all* that apply)

- ☐ Skin Disease: If so, what disease(s): _____
- ☐ Myasthenia Gravis
- ☐ Celiac Sprue ("celiac disease")
- ☐ Myositis ("inflammation" of muscles)
- ☐ HYPOthyroidism ("low" thyroid function)
- ☐ Cancer/Malignancy; Type: _____ YEAR DIAGNOSED: _____
- ☐ HIV Infection
- ☐ Diabetes
- ☐ Dyslipidemia (e.g. "high cholesterol," "high triglycerides," etc.)
- ☐ Heart Disease

OTHER SYMPTOMS related to PRP:

Regarding your MOOD, how often do you FEEL DOWN or DEPRESSED?

☐ Don't Know

☐ ALWAYS ☐ OFTEN ☐ SOMETIMES ☐ RARELY ☐ NEVER

In your opinion what percent of your DEPRESSION IS RELATED to PRP?

☐ Don't Know

☐ 0% (Not at all related) ☐ 1-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Extremely related)

List WHAT ABOUT YOUR PRP makes you feel DEPRESSED/IS HARD TO DEAL with:

☐ Don't Know

-example: people stare at me in public

-example: I am not allowed in the public pool because of my rash

END OF PATIENT SURVEY

PLEASE RETURN all pages of **this form** and the **research consent form** via:

1. **Email** (preferred): PRP@jefferson.edu

OR

2. **Mail**
   Department of Dermatology & Cutaneous Biology, Attn: Nick Ross,MD, 833 Chestnut St., Ste. 740, Philadelphia PA 19107. (If you require a stamped envelope, please contact (215) 503-3787).

OR

3. **Fax**:
   (215) 503-3333, attention PRP Study, Nick Ross, MD

Thank you for taking the time to complete this form. Your information is very helpful and will be used to advance dermatology's understanding of Pityriasis Rubra Pilaris (PRP).

10/5/17

Thomas Jefferson University
Informed Consent Document for Human Subjects Research – OHR-8

Department: Dermatology & Cutaneous Biology

Principal Investigator: Jouni Uitto, MD, PhD **Telephone**: 215-503-5785
Co-Investigator(s): Nicholas A Ross, MD; Qiaoli Li, Ph.D., Matthew Keller, MD
Key Personnel: Ashley Gochocco; Joshua Kingman, MS

Medical Study Title: Investigation of Potential Genetic Causes of Pityriasis Rubra Pilaris (PRP) by Mutational Analysis of Patient Tissues

Lay Study Title: A research study to enroll patients in a PRP registry, collect information about the presentation, diagnosis and management of the disease and identify genetic causes and pathways triggered by the disease

****

Is email a good method for study communication?
□YES □ NO
EMAIL: _____@_____

Please check BOXES (page 8) of the study sections in which you wish to participate

****

RISKS: E-mail correspondence is not always secure and there is a risk of loss of confidentiality. To help protect against loss of confidentiality, all e-mail that originates from Jefferson University or Jefferson Hospital employees using Jefferson University or Jefferson Hospital e-mail addresses is encrypted. That means, unless you have allowed others to have access to your e-mail, only you will see the e-mail. YOU SHOULD **NEVER** USE E-MAIL TO REPORT A SUSPECTED ADVERSE EVENT OR ANY OTHER MEDICAL PROBLEM. THESE SHOULD BE REPORTED BY TELEPHONE

What Is Informed Consent?

You are being asked to take part in a medical research study. As required by federal regulations, this research study has been reviewed and approved by an Institutional Review Board (IRB), a University committee that reviews, approves and monitors research involving humans. Before a knowledgeable decision about whether to participate in a research study can be made, the possible risks and benefits related to the study should be understood. This process of learning and thinking about a study before deciding to participate is known as *informed consent* and includes:

- Receiving detailed information about this research study;
- Being asked to read, sign and date this consent form once the nature of the study is understood and a decision is made to participate. If there is anything about the study you don't understand or if there are questions, you should ask for explanations before signing this form;
- Being given a copy of the signed and dated consent form to keep.

Can I enroll in the study?

Any patient with a diagnosis of PRP, WHETHER ACTIVE OR IN REMISSION, is permitted to enroll in this study. The study is divided into "goals" (see below) to improve data analysis and outcomes. You are allowed to enroll into both CURRENT and PAST goals at any time.

What is the purpose of this study and what will happen during this study?

This study has two Goal: Goal I includes genetic data analysis. Goal II includes clinical data analysis.

During Goal I, our research team seeks to identify genetic link and pathways involved in PRP. Analysis will involve patient saliva (spit)/buccal smear (cheek swab), blood and skin samples. This portion of the study is always open for sample enrollment.

Three steps of Goal I:

1. You will receive information and this consent form allowing study personnel to request a biological specimen from you (either blood, saliva, cheek swab or skin biopsy).
2. If interested in participating, you will complete the consent form, which you may review at your own pace, returning all completed forms and biologic specimens to our Clinical Research Office.
3. Our study team will use specimens provided to perform genetic mutational analysis and compare your specimen with all other specimens collected. When we have achieved a sufficient number of specimens and analysis is complete, the data will be published and you will be informed of our findings.

During Goal II, there are no tests. Our aim is to gather clinical information from patients regarding their experience, symptoms, and treatment of PRP. We request your permission to allow study team members (listed above) to contact your diagnosing/treating physician(s) to acquire medical records (clinical and/or pathologic) and/or skin biopsy slides. Specifically, we seek your permission to contact your physician in order to confirm your diagnosis of PRP. We also request permission for study personnel to contact you, solely for the purpose of obtaining these documents and information related to the PRP study. Through this research, we hope to establish a possible genetic link of the disease that can enable further research that may improve diagnosis and treatment options.

The three steps of Phase II are:

1. You will receive information regarding the study (Patient Study Packet), which you may review at your own pace.
2. If interested in participating, you will complete the (i) Consent Form, (ii) Release of Medical Records form and (iii) Patient Questionnaire and return all documents (all pages included) to our Clinical Research Office.
3. Our study team will use information provided in the study packet to contact your physician(s) and gather your clinical and/or biopsy records in order to review and confirm your diagnosis of PRP. We seek medical records containing clinical (doctor's notes) and/or pathologic (biopsy) reports and/or biopsy slides that will allow us to definitively establish your diagnosis of PRP through pre-defined study criteria. The goal is to collect this information and allow the physicians associated with this study at Thomas Jefferson University's Department of Dermatology and Cutaneous Biology to review the diagnosis for study purposes.

Once you provide your medical records and/or samples, the following will occur:

Documents will be reviewed for pertinent information that may identify triggers (medications, illnesses, other conditions at the time of PRP onset), information useful for diagnosis and treatment of the disease as well as long term outcomes. Samples will be kept in a locked -80C freezer at Dr. Uitto's research laboratory. Tissue samples will be used to study the genetics and pathways involved in the disease. DNA will be extracted from the sample you provide; we will analyze it to identify mutations, specifically in the CARD14 gene that is associated with the disease. Skin biops(ies) will be examined for target gene (*CARD14)* involvement, immuno-histochemical staining and upregulation of inflammatory pathways. This may allow for a better understanding of the pathways involved in the disease and better, targeted treatment options.

How many individuals will participate in the study and how long will the study last?

The goal is to enroll as many participants as possible in the PRP registry to expand the quality and quantity of research and improve patient access to PRP research. To date, more than one hundred PRP patients, just like you, are participating in this research study.

You can enroll if you have ACTIVE OR RESOLVED PRP. Your participation in any Goal of the study will last only as long as it takes you to complete the documents followed by the time it takes our study team to obtain clinical records from your diagnosing/treating physician(s) (approximately six months to one year). Once information has been gathered, you will have "completed" your enrollment in the study; we will maintain your information, however, to

continue to reach out to you about progress and subsequent Goals of the study. Your participation, of course, is voluntary and can be terminated at any time at your request or at the discretion of the principal investigator.

What are the side effects and other risks or discomforts involved?

Saliva (spit)/Buccal Swab (Cheek Swab) Sample

Providing a saliva (spit)/buccal smear (cheek swab) sample involves spitting into a sterile specimen container or using a specimen cotton tip collector and stroking the inside of the cheek to collect skin cells.

What are the Risks of Saliva (spit)/Buccal Swab (Cheek Swab) Sample?

There are no risks associated with this specimen collection.

What Are the Risks of Drawing Blood?

If you choose a blood draw method: The amount of blood drawn will be about 10 milliliters **(2 teaspoons)**; only one sample is required at this time. The risks of blood sampling are the same as any routine blood draw including discomfort as the needle is inserted, bleeding, bruising and discoloration around the site of the blood draw, infection and, rarely, fainting. Risks will be minimized by having the blood drawn by an individual who is trained to perform this procedure.

What Are the Risks of Skin Biopsy?

If you choose a biopsy (skin sample) method: You may have a skin biopsy performed on both affected (eg. rash) and non-affected (eg. normal) skin. The risks of skin biopsy are discomfort during anesthetic administration, bleeding, bruising at the site, infection at the site, scar and, rarely, fainting. Risks will be minimized by having the biopsy performed by a trained professional.

What is the risk of releasing my medical record?

By releasing your medical records, there is always a risk of a breach in confidentiality. By following preventative privacy measures outlined in the study protocol, we hope to minimize this risk. All information we obtain will be kept confidential and protected in a secure, on-campus office within a locked file cabinet. Your name will not be linked to any published data.

Are there benefits from being in this study?

There may be no personal benefit from being in this research, but we hope that what we learn may be helpful to future patients or society, in general.

Are there alternatives to being in the study?

Participation in this study is entirely voluntary. The alternative is not enrolling in the study. You do not have to complete the study survey nor do you have to provide permission for our study team to contact your treating/diagnosing physician. If, however, you are interested in participating, please complete all study forms.

How will privacy and confidentiality (identity) be protected?

Federal regulations require that certain information about individuals be kept confidential. This information is called "protected health information" (PHI). PHI includes information that

identifies an individual personally such as name, address and social security number, or any medical or mental health record, or test result, that may have this sort of information on it. The laws state that people may see and review their medical records at any time. However, in a research study, people may not see the study results or other data about the study until after the research is completed unless the study doctor decides otherwise.

The following individuals or entities may have access to your/your child's (if enrolled) PHI and by law must protect it. These include investigators listed on this consent form and other personnel of Thomas Jefferson University, Jefferson University Physicians, and Thomas Jefferson University Hospitals, Inc. (add the Rothman Institute if applicable) involved in this specific study, the University's Office of Human Research and the Institutional Review Board (IRB), and your/your child's (if enrolled) health insurance company (if necessary for billing for standard medical care).

PHI collected during this study may also be shared with the following entities that, while not obligated by law to protect PHI, will protect it to the best of their ability:

- The National Institute of Health (NIH) if supplying grants in the future
- With any person or agency required by law

If you develop an illness or injury during the course of participation in this study, other PHI about treating and following the condition may be generated and disclosed as it relates to this study.

PHI collected as part of this research may be used/disclosed indefinitely.

You may quit the study and revoke permission to use and share PHI at any time by contacting the principal investigator, in writing, at: **Jouni Uitto, MD, PhD, Professor and Chair, Department of Dermatology & Cutaneous Biology, Thomas Jefferson University, 233 South 10th Street Bluemle Life Sciences Building, Room 450, Philadelphia, PA 19107.** Further collection of PHI will be stopped on those who quit the study, but PHI that has already been collected may still be used.

The results of clinical tests and procedures performed as part of this research may be included in your medical records. The information from this study may be published in scientific journals or presented at scientific meetings but no one will be personally identified in these publications and presentations.

A description of this clinical trial will be available on http://www.ClinicalTrials.gov, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.

What happens in case of injury as a result of being in this study?

In the event of a research-related injury, necessary and available medical care (including hospitalization) will be provided. A research-related injury is a physical injury or illness that is directly caused by any procedure or treatment used in this study that is different from the treatment you would receive if not participating in a research study. If physical injury occurs due to any drug/substance or procedure properly given under the plan for this study, medical

expenses for treating the injury will be billed to your insurance carrier. You should be aware that some costs may not be covered by insurance and may become your responsibility.

If a bill related to a research-related injury is received that seems wrong, please discuss it with the study doctor or research coordinator.

Is there payment for being in this study?
There is no payment for participating in this study.

Are there costs related to being in this study?
The only cost to you with participating in this study is for postage to mail the forms. If you are unable to afford this cost, please contact our study team (information below) to request assistance. the clinical research fellow (information in the patient study packet) who can assist you in finding alternative means of supplying the study team with your documents.

What if the research results in new findings?
Anything learned during the study, beneficial or not, that may affect your health or willingness to continue in the study, will be explained.

Can I be removed from the study or quit the study?
Your decision to participate in this research study is entirely voluntary. You have been told what being in this study will involve, including the possible risks and benefits.

Your participation in this research project may be terminated by the study doctor without your consent for any reason that he/she feels is appropriate.

You may refuse to participate in this investigation or withdraw consent and quit this study without penalty and without affecting the ability to receive medical care at Thomas Jefferson University/the Rothman Institute.

If you withdraw from this study, you may continue treatment with your Jefferson doctor, or you may seek treatment from another doctor of your choice. Should you decide to withdraw from the study, please be sure to inform the study doctor.

THIS SPACE IS INTENTIONALLY LEFT BLANK

CONTACT INFORMATION

If you are having a medical emergency, call 911 or go directly to an emergency room. You should let emergency personnel or providers know that you are participating in this study.

PRP Study Group Contact Information

Email (preferred)	PRP@jefferson.edu	Note: this mailbox is checked periodically.
Mail	833 Chestnut Street, Suite 740, Philadelphia PA 19107, USA	Mark attention: PRP Study Nicholas Ross, MD
Fax	215-503-3333	Mark attention: PRP Study Nicholas Ross, MD

Other Useful Contact Information

Telephone number for questions about your rights as a research participant	The Jefferson Institutional Review Board	215-503-8966
For questions, concerns or complaints about the research, or if you suspect a research-related injury	The Principal Investigator, Dr. Jouni Uitto, MD, PhD or any co-investigator listed at the beginning of this form	***215-503-5785***
If you have difficulty contacting the study staff	Call the Jefferson Office of Human Research	215-503-0203

If you want more information about the Jefferson Institutional Review Board or Jefferson's Human Research Protection Program, please visit our website at http://www.jefferson.edu/human_research/irb/index.cfm.

Non-Waiver of Legal Rights Statement

- By your agreement to participate in this study, and by signing this consent form, you are not waiving any of your legal rights.
- In order to be in this research study, you must sign this consent form.
- You affirm that you have read all pages of this consent form. You have been told that you will receive a copy.

Please **ENROLL ME IN** the following (*check all parts you wish to join)*:

1. Clinical Survey / PRP Registry
□**Yes** □**No**

2. Genetic Analysis (*check all methods you allow*)
□**Yes** □**No**…..a. **Saliva (spit)/buccal smear (cheek swab) Sample**
□**Yes** □**No**…..b. **Blood Sample**
□**Yes** □**No**…..c. **Skin Biopsy**

Your Name	Your Signature	Date
Name of **Person Conducting Consent Interview**	Signature of **Person Conducting Consent Interview**	Date
Name of **Investigator or Co-Investigator**	Signature of **Investigator or Co-Investigator**	Date

☐ **Copy of Signed and Dated Consent Form Given to the Subject/Parent/LAR**

Your Name **(if Minor)**	Your Signature **(if Minor)**	Date

(If subject is a minor and this document is being used both as consent and assent form.)

Name of **Witness**	Signature of **Witness**	Date

(Witness only required if subject speaks and understands is English, but the subject cannot read English, the subject is blind or cannot physically sign the consent form)

10/5/17

By signing, you give permission to your diagnosing/treating physician to release your medical record(s), biopsies/slides to the Thomas Jefferson University PRP Research Team for the purposes of scientific study.

****Instructions****

Please enter **diagnosing physician information** (e.g. dermatologist).
If you saw multiple physicians/dermatologists for the diagnosis please attach additional pages as necessary.

1. **PHYSICIAN Name:** _____
2. **PHYSICIAN Telephone:** _____
3. **PHYSICIAN Fax:** _____
4. **PHYSICIAN Address:** _____

_____

City _____ State/Province _____

Postal Code _____ Country _____

I hereby authorize the physician(s) listed above to release my medical records to the research personnel listed above at Thomas Jefferson University Hospital for the purposes of scientific study.

_____	____/____/____	_____
Print **YOUR** Name	**YOUR** Date of Birth	**YOUR** Telephone Number

_____	____/____/____
Signature	Date

_____	____/____/____
Witness Signature	Date

(Witness required if the only language the subject speaks and understands is English, but the subject cannot read English, or if the subject is blind or cannot physically sign the consent form.)

10/5/17