**Written Patient Consent Form**

We would like to ask you to take part in a written patient case description regarding the treatment of your wound.

The case will be used for marketing, educational and informational purposes to health care professionals and employees in the health care system. In addition to the written information, photographs of the wound and the surrounding area will be taken. We will not take photographs of your face and you will have the opportunity to see the photographs.

The case description is not a part of a study investigation and information on the treatment of your wound is purely of educational character.

Your identity will be known to the doctor/nurse treating your wound but you will be completely anonymous to all other parties.

All information that you give to **[insert trust name]**, is the property of **[insert trust name]** and the usage of such information will not result in any compensation.

If preferred you are at any time able to withdraw this written patient consent without any consequences for your future treatment. However, because you are anonymous it is not possible to withdraw the consent after the treatment period of this case description has ended.

I, , hereby consent that **[insert trust name]** as a third party, may freely use the information and photographs taken of my wound in connection with my treatment with Coloplast's wound care products in **[insert country]**. I accept that data might be published on congresses, in medical journals and on Coloplast hosted websites on the Internet.

Data will be collected and processed across Coloplast’s network which may include processing of personal data outside of the European Economic Area. Coloplast fully endorses and adheres to the principles of data protection as set out in the European Data Protection legislation. For more information about data privacy please refer to [www.coloplast.com/global/privacy-notice](http://www.coloplast.com/global/privacy-notice). I agree to visit the site for further information.

Date \_\_\_/\_\_\_/ \_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient number \_\_\_\_\_\_\_\_\_