



# Renaissance School of Medicine

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Place Patient Identification Sticker Here

## Consent For Use of Medical Information for Case Report Publication

I, \_\_\_\_\_ give my consent for Stony Brook University Hospital, Department of Anesthesiology, to share my medical information with other physicians for educational purposes only. I understand that my privacy would be protected and my name or any other information that might identify me will not be used in the communication.

I understand that information will be published without my name attached and that the publishers of the case report will make every effort to ensure my anonymity although it is possible that somebody, such as a member of staff or a relative, may be able to identify me.

I declare, in consequence of granting this permission, that I have no claim on ground of breach of confidence or any other legal system against the authors, presenters, journal editors or publishers.

I hereby agree to release and discharge the author and any editors or other contributors and publishers from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy of copyright or violation of any other rights arising out of or relating to any use of my image or case history.

I understand that my agreement to consent to publication is voluntary and that I am free to refuse to grant my permission without it changing the quality of care I receive or will receive in the future.

I can withdraw my consent up to the time when the manuscript is accepted for publication when this will no longer be possible.

<b>Patient Signature</b>	<b>Patient Name</b>	<b>Date</b>
<i>If signing on behalf of the patient, please give the reason why the patient can't consent for themselves (e.g. patient is deceased, under 18 or has cognitive or intellectual impairment).</i>		

*Practitioner Obtaining Consent:*

<b>Practitioner Signature</b>	<b>Practitioner Name</b>	<b>Date</b>
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