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To whom it may concern:

I give my permission for _____ to use the de-identified medical and personal information of _____ to create and publish a case report for publication in a scientific medical journal. I understand that, if I have additional questions or concerns, I should contact _____ in the Department of Anesthesiology at the address listed above.

_____
Signature of Patient or Legally-Authorized Representative

_____
Written Name of Patient

_____
Written Name & Relationship of Legally-Authorized Representative

_____
Date & Time