

PERMISSION FOR PUBLICATION OF PATIENT INFORMATION

Name of person described in article: _____

Manuscript number: _____

Title of article: _____

Author: _____

I _____ [insert full name] authorize the health-care provider/author named above to disclose portions of my personal medical information (“Information”) to the American College of Chest Physicians (“ACCP”) and to the Journal *CHEST*. I have also been given the opportunity to read the manuscript containing my Information.

I understand and agree to the following:

1. Although the Information will be published without my name attached, I understand that based on the Information, I may be recognized by myself or others.
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4. I understand that if I refuse to give permission to publish the information, my refusal will prevent the disclosure of such Information, but will not affect the health-care services I presently receive, or will receive.
5. I understand that I can withdraw my permission in writing at any time, but doing so will not affect any prior publication.
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7. I can contract in my own name.

Signature

Date

If patient is a minor or otherwise incapable of executing the Permission for Publication of Patient Information:

I have read the above Permission. I am the parent, guardian, or conservator of

_____, a minor. I have the authority to sign this permission on his/her behalf.

Signature

Date

