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.

2. The Information may be published in CHEST, which is read worldwide in print and online (http://publications.chestnet.org). While the primary audience of CHEST is physicians, it is also seen by non-physicians, including journalists.

3. The Information may also be used in full or in part in other publications and products published by ACCP or other publishers to whom the ACCP licenses its content. This includes publication in English and in non-English translations, in print, in electronic formats, and in any other formats that may be used by ACCP or its licensees now and in the future.

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.

6. I release the Provider, ACCP, and all parties acting under their license from any payment claim related to distributing or publishing of the Information by ACCP, CHEST or their licensees.

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