



UNIVERSITY OF KENTUCKY

To whom it may concern:

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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