

**Department of Anesthesiology**  
**University of Maryland School of Medicine**  
**University of Maryland Medical System**

**Authorization for Use of Patient Information and Photographs**

**for**

**Professional Training, Teaching and Publication of Scholarly Articles Such as Case Reports**

The Department of Anesthesiology at University of Maryland School of Medicine and the University of Maryland Medical System is committed to educating and training health care professionals and to advancing health care through publication of scholarly articles such as a report of your medical condition and the treatment that you received (i.e., a case report). We appreciate the help of our patients who are willing to share information about their care to assist us in these important efforts.

We respect the privacy of our patients and the confidentiality of patient medical information. Case Reports are articles in the medical literature that describe an unusual medical condition or unusual medical situation. Although we will take all possible measures to keep your identity anonymous, it is possible that your identity could be unintentionally revealed because of the unusual nature of your case. **The case reports will NOT disclose your name, date of birth, where you live, or exact dates of your medical care, but may list your age and gender.** We need your authorization before we can use information about your health care for professional training, teaching and publication of such articles.

By signing this form, you give the Department of Anesthesiology permission to use information and photographs relating to your care to advance our mission of educating and training health professionals and furthering health care developments through the publication of such articles.

**At any time before the manuscript is submitted, you may contact us and withdraw permission granted by your signature below. You may request a copy of the manuscript be forwarded to you after it is published.**

**The care provided to you by University of Maryland School of Medicine and University of Maryland Medical System staff members will not be affected by your decision about whether to sign this form.**

Range of dates care was provided:

Date:

Time:

Signature of patient or surrogate:

Relationship to patient, if surrogate:

Signature of healthcare provider:

Healthcare provider printed name or ID #:

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