CONSENT AUTHORITY FOR USE AND RELEASE OF RECORD

***I**(full name of patient)…………………………………………..……………………DOB …../..../…..

Of(address)……………………………………………………………...in the State of ……………….,

Consent and authorise Dr……………………………………………………………………………..

Of(address)……………………………………………………………………………………………..

in the State of ……………………………. to release my de-identified patient information for the purpose of Research and publication.

***As guardian of**

(Full Name of patient)…………………………………………..……………………DOB…./…./…

Of(address)…………………………………………………………….…in the State of…………

I(Guardian's name)………………………………………………….Relationship………………..

Of(Guardian's address)……………………………………………………………………………….

Consent and Authorise Dr……………………………………………………………………………

Of(Address)……………………………………………………………………………………………

In the State of……………… To release (name of Patient)……………………………………..'s

de-identified patient information for the purpose of Research and Publication.

(*Only fill out relevant section)

I consent and authorise the use of the above patient's information on the understanding that it will be de-identified.

Signature ……………………………………………………………..

Date ……………………………………………………………..

Witness ……………………………………………………………

Date …………………………………………………………….