CONSENT FORM FOR CASE REPORTS

I give my consent for my health and treatment information to appear in a journal article, or to be presented during a conference as part of a speech or poster display.

I understand the following:

1. My decision to consent to the use of my health and treatment information in an article or presentation will not affect the medical care I receive at Henry Ford St. John Hospital. Henry Ford St. John Hospital cannot require me to sign this consent form as a condition for treatment.
2. My health and treatment information will be published without a name attached and every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that someone somewhere may identify me. For example, someone may be able to identify me based on the institution location and information available on my social media accounts.
3. My health and treatment information may appear on an association website, in a medical journal or be presented at professional conferences for educational purposes. Journals articles are aimed mainly at health care professionals but may be seen by many non-doctors, including journalists.
4. I will not receive financial benefit, including royalties or compensation for giving my consent to use my health and treatment information in this case study.
5. I can withdraw my consent at any time before there is a commitment to publish or present content containing my health and treatment information. To withdraw consent sent a written request to:

   Dr. Susan M. Szpunar, 19251 Mack Avenue, Suite 340, Grosse Pointe Woods, MI. 48236

   Sszpuna2@hfhs.org

   313-343-7838

Patient's Name: _____ Check if Patient is deceased? ☐

Subject matter of article or presentation:

_____

Title of article or presentation:

_____

Medical practitioner or corresponding author: _____

If the case report contains photography or video, the Authorization for Photography, Video, and Recording must be signed.

Please retain a copy of the signed consent form for your records.

I release [Insert Name of Institution], its agents, and employees from any liability arising out of the distribution of my treatment information.	
Signature:	Date signed:
Signature of Authorized Representative:	Relationship:
Signature of Requesting Author	Date signed: