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Author(s):

I hereby give my consent for images of letters/prescriptions/comments or other clinical information relating to this patient case to be on the website www.coxtechnic.com.

I understand that my name, initials, or any protected health information such as my identification number, billing information, address, etc. will not be published and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed.

HOWEVER, if you do NOT want your name/address/identity concealed, please sign here:

Signature for NO ANONYMITY

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Name of physician

Signature of physician (or signature of the person giving consent on behalf of the patient)

Date

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