CONFLICT OF INTEREST

Title: Florid reactive periostitis ossificans of the humerus: Case report and differential diagnosis of periosteal lesions of the long bones.

Author: Abha Soni, Alec Weil, Shi Wei, Kenneth A Jaffe and Gene P Siegal

The authors of this manuscript declare no conflict of interest in the subject matter or material discussed in this manuscript.

Corresponding author name: Gene P. Siegal MD, PhD

Signature: _____

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTE

Informed consent. Is this sufficient? -abha

Patient Name: Grace Sayon Lee Date:

Date of Birth: Sept. 12, 1974

I consent for medical records and/or medical photographs to be used of me (or persons for whon legal guardian). I understand the information gathered by my physician may be used for purpose: medical teaching, or for publication in medical textbooks or journals. By consenting I understand will not receive payment from any party. Refusal to consent will in no way affect the medical car receive. If I have any questions or wish to withdraw my consent in the future, I may contact:

Dr. Kenneth Jaffe - 205-802-6700

By signing this form below, I confirm the consent form has been explained to me in terms which I understand.

1. I consent for my medical records to be used in medical publications, including medical jo textbooks and electronic publications. I understand they may be viewed by members of t general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these records and/or photographs used without identifying information such as my name; I understand that it is possible fo someone to recognize me. I also consent to allow these publications to be used for teach purposes.

Grace S. Lee (Signature)

(Witness)

2. I do not give consent for my medical records and/or medical photographs to be used for publications or teaching purposes.

(Signature)

(Witness)

For patients below the age of 18, a signature below indicates that you are the legal guardian ar give consent for the minor in question.

I agree that it has been explained to me by my guardian the use of my medical records.

(Signature of Minor)

I agree that I have explained the authorization to the patient/minor.

(Signature of Patient)