

I, [REDACTED], give Dr. Rubin and his co-authors at Northwell Medical Center (Zucker School of Medicine at Hofstra/Northwell), permission to publish, reproduce, and distribute the case report regarding Hereditary Diffuse Gastric Cancer. I am aware that the case report does NOT mention my name or address, but it does reflect my medical care, gender, and medical history.

I have been told that the authors currently plan to submit the case report for publication in a medical journal, for educational purposes.

I will not be paid in any manner for use of the case report, as described above. I will not receive any royalties or other compensation in connection with any such publication or use.

I am not required to sign this form, and I may refuse to do so. My medical treatment and payment for healthcare will not be affected by whether or not I sign this document.

I may withdraw this authorization for any future sharing at any time by notifying my physician in writing, but my withdrawal will not affect information that has already been shared or published. This authorization has no expiration date.

[REDACTED]  
Patient Name

11-7-17  
Date

[REDACTED]  
Patient Signature

Physician/ Author Signatures:

Steven Rubin

Steven Rubin MD

11/7/17 100  
Date

[Signature]  
Signature

Keith Sultan

Keith Sultan

Signature

11/8/17  
Date

Haley Zylberberg

Haley Zylberberg  
Signature

11/8/17  
Date