

AUTHORIZATION FOR PUBLICATION OF CASE STUDY:

I give Dr Harpal S. Dhaliwal and his team at Christian Medical College, Ludhiana, permission to publish, reproduce and distribute the attached Case Study, regarding Endoscopic management of hypopharyngo-esophageal strictures using a novel technique. I am aware that this case study does not mention my name or address, but it does reflect my medical care, age, gender and medical history.

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

I will not be paid in any manner for use of the Case Study, 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 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 attending doctor in writing, but my withdrawal will not affect information that has already been shared or published. This authorization has no expiration date.

Patient's Name: [REDACTED]

Patient's Address: [REDACTED]

Hospital ID: C721318

Patient's Signature and date: [REDACTED]

30/6/2018

Reviewed by Dr Harpal S. Dhaliwal:

Signature: HSD

Date & Time: 30 June 2018 (3:30 pm)

AUTHORIZATION FOR PUBLICATION OF CASE STUDY:

I give Dr Harpal S. Dhaliwal and his team at Christian Medical College, Ludhiana, permission to publish, reproduce and distribute the attached Case Study, regarding Endoscopic management of hypopharyngo-esophageal strictures using a novel technique. I am aware that this case study does not mention my name or address, but it does reflect my medical care, age, gender and medical history.

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

I will not be paid in any manner for use of the Case Study, 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 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 attending doctor in writing, but my withdrawal will not affect information that has already been shared or published. This authorization has no expiration date.

Patient's Name: [REDACTED]

Patient's Address: [REDACTED]

Hospital ID: C723618

Patient's Signature and date: [REDACTED]

(Pr39) - 26-6-2018)

Reviewed by Dr Harpal S. Dhaliwal:

Signature: HSD

Date & Time: 26 July, 2018 (10:00 am)