

**CONSENT FOR THE PUBLICATION OF  
MEDICAL IMAGES, RESULTS, AND  
CLINICAL INFORMATION IN A  
MEDICAL JOURNAL**

- ☐ Geisinger Medical Center, Danville, PA 17822  
☐ Geisinger Wyoming Valley Medical Center, Wilkes-Barre, PA 18711  
☐ Geisinger Shamokin Area Community Hospital, a campus of  
Geisinger Medical Center, Coal Township, PA 17866  
☐ Geisinger Community Medical Center, 1800 Mulberry Street,  
Scranton, PA 18510  
☐ Geisinger Bloomsburg Hospital, Bloomsburg, PA 17815  
☐ Geisinger Lewistown Hospital, Lewistown, PA 17044  
☐ Geisinger Holy Spirit, Camp Hill, PA 17011  
☐ Geisinger Jersey Shore, Jersey Shore, PA 17740  
☐ Geisinger \_\_\_\_\_

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

I, the undersigned, give permission to Geisinger and its personnel to use and publish my images, laboratory results, and clinical information in the print, online, and/or licensed versions of one or more medical journals. In granting this permission, I understand that my name will not be published and the authors will take measures to protect my identity, but that complete anonymity cannot be guaranteed.

Such images, results and clinical information may be published, reproduced, exhibited, copyrighted, used in and published anywhere in the world in any manner whatsoever (including advertising related solely to promotion) without further consent from or payment to me. I hereby forever release and discharge the authors, the journal(s), their employees and employers, licensees, agents, successors, and assigns from any claims, actions, damages, or demands whatsoever by reason of any such use.

**DO NOT SIGN THIS FORM UNLESS YOUR QUESTIONS HAVE BEEN ANSWERED**

I have enough information to make a decision.

Signed By: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

☒ Patient

☐ Patient Representative

☐ Parent or Legally Appointed Guardian

☐ Interpretation service used: \_\_\_\_\_

Language: \_\_\_\_\_

If using a patient representative, please specify relationship to the patient:

If using patient representative, please specify reason patient was unable to sign:

Obtained By: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

**DO NOT SCAN INTO PATIENT'S MEDICAL RECORD**