

PERMISSION TO RELEASE INFORMATION

Web Content

I, _____, agree to allow the Department of Orthopedics at the University of Washington to use information about myself, and my surgery to document the success and scope of the Orthopedics Department and the physicians who treated me. The information can be posted on the web site, submitted to the granting agencies for posting on their web site, and can be included in the progress reports submitted to the granting agencies and the university. The information that I'm allowing to be used includes photos taken, my name, e-mail address, institutional affiliation.

Signature:

Dated: