

## Patient Consent for Publication

The following information must be provided in order for this form to be processed accurately.

**Patients have the right to refuse to sign this consent form; refusal to sign this form will not affect their care in any way.**

- I hereby give my consent for images or other clinical information relating to my case to be reported in a medical publication.
- I understand that my name and initials will not be published and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed.
- I understand that the material may be published in a journal, Web site or other form of publication. As a result, I understand that the material may be seen by the general public.
- I understand that the material may be included in medical books.

\_\_\_\_\_  
*Name of the patient*

\_\_\_\_\_  
*Patient's date of birth*

\_\_\_\_\_  
*Signature of patient (or signature of the  
Person giving consent on behalf of the patient)*

\_\_\_\_\_  
*Date*

If you are not the patient, what is your relationship to him or her? (The person giving consent should be a substitute decision maker or legal guardian or should hold power of attorney for the patient).

\_\_\_\_\_

Why is the patient not able to give consent? (e.g. is the patient a minor, incapacitated or deceased?)

\_\_\_\_\_

**If images of the patient's face or distinctive body markings are to be published, the following section should be signed in addition to the first section:**

I give permission for images of my face or distinctive body markings to be published and recognize that I might therefore be identifiable even though my name and initials will not be published.

\_\_\_\_\_  
*Signature of patient (or signature of the  
Person giving consent on behalf of the patient)*

\_\_\_\_\_  
*Date*