

## Patient Consent for Publication

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

Title: \_\_\_\_\_

Author(s): \_\_\_\_\_

I hereby give my consent for images or other clinical information relating to my case to be reported in the (Journal)\_\_\_\_\_.

I understand that my name, initials, or any protected health information such as my identification number, billing information, address, etc. will not be published and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed.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 the above journal, on above journal's Web site and in products derived from the journal. As a result, I understand that the material may be seen by the general public.

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
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markings to be published and recognize that I might therefore be identifiable even though my name and initials will not be published.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

**Please complete all required fields before returning to the journal**