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PATIENT CONSENT FORM

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give my consent and authorize the journal (both print and online edition) to use the image(s) and related information during my treatment. I understand that such imaging records and information may be published by Journal of Medical Academics and/or any party acting under the license and authority of Journal of Medical Academics, in any print, visual, electronic or broadcast media, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public about surgery methods, results, issues, trends, concerns and similar matters.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive.

I understand that my name and identity will not be disclosed. Once signed, I cannot revoke my consent.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above information and fully understand its terms.

I hereby warrant that I am over twenty-one years of age, and competent to contract in my own name.

Name of patient:

Date of Birth (DD/MM/YY):

Signature/thumb impression of patient (or signature/thumb impression of the person giving consent on behalf of the patient):

Relationship to the patient in case of other person signing/providing thumb impression for the consent:

Address:

Date:

**For minor patients:**

I am the parent, guardian or conservator of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Name of the patient:

Name of the parent, guardian, conservator:

Signature/ thumb impression of the parent, guardian, conservator:

Address:

Date: