Journal of Postgraduate Medicine Education and Research**:PATIENT CONSENT FORM (For Clinical Images)**

Manuscript ID.:

Patient's Registration number:

Title of manuscript:

Name of authors:

Corresponding author: (with e- mail):

To be signed by the patient:

I hereby give my consent and authorize the journal 'Journal of Postgraduate Medicine Education and Research' (both print and online edition) to use the image(s) and related information during my treatment.

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

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: