# Preface

This template has been developed to assist researchers seeking consent to include patient information in a case report. The wording below is based upon that provided by the Medical Journal of Australia consent template.

Wording provided below is a recommendation only and may be changed as necessary to suit the context.

**PLEASE DELETE THIS PAGE PRIOR TO SUBMISSION**

# Consent for publication of personal material in a case report or series

Title of article:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Corresponding author’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person described or pictured: I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

give permission for material about me (or my child/ward/relative) to be published in a medical journal <<may wish to name the specific journal if known at the time of consent>>.

I understand that:

* The use of my material may include publication of the material in all formats (including print and online). The material will not be used for advertising, packaging or financial gain.
* I understand that my name will not be published and that every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed, for example, members of my family or the health care staff who have looked after me may recognise me from the image and/or the accompanying text.
* The article may be the subject of a media release and may be linked to from social media.

Please tick the appropriate box below:

 I have read the manuscript or a general description of what the manuscript contains and seen all images of me (or my child/ward/relative) that are proposed to be published.

*or*

 I have been offered the opportunity to read the manuscript and view the images of me (or my child/ward/relative) that are proposed to be published, but I waive my right to do so.

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Signature of patient/subject of report Date

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Name of patient (please print) Patient UMRN