Patient Consent Form

Please complete the Patient Consent Form below and fax it to (313) 577-6718 or scan and email it to jabfm@med.wayne.edu.

For a patient's consent to publish personal information about him or her in a clinical case report.

FOR THE CORRESPONDING AUTHOR TO COMPLETE:

Print name of person described in case report or shown in photograph:

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Description of patient material:

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Printed name of person obtaining signature:

____

Signed name of person obtaining signature:

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FOR THE PATIENT TO COMPLETE:

I understand the following and give my consent for this information to be published about MYSELF/MY CHILD OR WARD/MY RELATIVE [circle correct description]:

1. The information will be published without my name attached and every effort will be made to protect my anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody may identify me, such as relative or a health professional that cared for me.
2. If the manuscript is accepted for publication, the information will likely be published both in print and online.
3. My personal information will not be used for marketing or advertising purposes. Also, the information should not be taken out of context of the manuscript.
4. I may withdraw my consent at any time before publication. However, once the manuscript has been sent to be processed for publication, my consent can no longer be withdrawn.

Signed:

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Date:

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FOR THE EDITORIAL OFFICE TO COMPLETE:

Manuscript Number:

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Title of Article:

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Corresponding Author:

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