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Patient Permission Form

I_____ consent to the Journal of the Association of Physicians of India using images and relevant information from my treatment. I understand these may be published by the Journal or its authorized parties in print, visual, electronic, or broadcast media, including medical journals, textbooks, scientific presentations, teaching courses, and internet websites. The purpose is to inform the medical community or public about surgical techniques, outcomes, issues, trends, concerns, and related topics.

- I understand that I may decline to sign this authorization, and that doing so will not affect my medical treatment.
- I understand that my name and identity will remain confidential. Once I sign, my consent cannot be revoked.
- I am voluntarily providing this consent for public education and confirm that I have read and fully understand the terms above.
- I confirm that I am over 18 years of age and capable of entering into contracts 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: