Case Report Consent Form

Patient Name: _____ Personal I.D No.: _____

Description of the identifiable materials as (Photographs, images, texts, or any material about the patient). (**A copy of the Material should be attached to this form**):

_____

_____

Provisional title of article in which Material will be included (the title should give indication to the aims and importance of the report):

_____

_____

_____

CONSENT

I _____(PRINT FULL NAME)

Relationship to patient (if patient not signing this form): _____.

Give my consent for the material about me/ the patient to appear in the publication (Type of publication):

_____

I confirm that: (please tick boxes to confirm)

- ☐ **I have seen the photographs, images, texts or other material about me/ the patient**
- ☐ **I`m legally entitled to give this consent.**

I understand the following:

1. The Material will be published without my / the patient's name attached, however I understand that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - for example, somebody who looked after me/ the patient or a relative - may recognise me/ the patient.
2. The Material may show or include details of my "the patient's" medical condition or injury and any prognosis, treatment or surgery that I have/ the patient has, had or may have in the future.
3. The article may be published in a journal which is distributed worldwide. Publications in the medical field viewed mainly by doctors and other healthcare professionals but are also seen by many others including academics, students and journalists.
4. The article, including the material, may be the subject of a press release, and may be linked to from social media and/ or used in other promotional activities. Once published, the article may be available on any website.
5. I/ The patient will not receive any financial benefit from publication of the article.
6. The article may also be used in full or in part in other publications and products published by any other publishers. This includes publication in English and in translation, in print, in digital formats, and in any other formats that can be used now and in the future.
7. This consent form will be retained securely and in confidence by our institute in accordance with the law and regulations, for no longer than necessary period.

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Please tick boxes to confirm the following:

☐ I consent to King Abdullah University Hospital (KAUH) storing my contact details for the sole purpose of contacting me, if necessary, in the future.

Printed Name: _____ Personal I.D No.: _____
Address: _____ Telephone no: _____
Email address: _____ Signature: _____
Date: _____

If signing on behalf of the patient, please give the reason why the patient can't consent for themselves (e.g. patient is deceased, under 18 (they must confirm the consent of the participants' legally authorized representative) or has cognitive or intellectual impairment):

Details of the person who has explained and administered the form to the patient or their representative (e.g. the corresponding author or other person who has the authority to obtain consent).

Printed Name: _____

Institution: _____ Position: _____

Address: _____ Telephone No: _____

Email address: _____ Signature: _____

Date: _____