PATIENT CONSENT FORM

(For Clinical Images)

Manuscript Ref. No.:

Patient's Registration number:

Title of manuscript:

Name of authors (Only two):

Corresponding author:
(With E mail)

To be signed by the patient

I hereby give my consent for image(s) and clinical information related to me to be reported in the *Indian Journal of Medical Research* (both in print and electric edition).

I understand that my name and identity will be concealed.

Once signed, I cannot revoke my consent.

Name of patient:

Date of Birth (DD/MM/YY):

Signature of patient (or signature of the person giving consent on behalf of the patient):

Relationship to the patient in case of other person signing the consent:

Address:

Date: