PATIENT CONSENT FOR CLINICAL PHOTOGRAPHY AND EDUCATIONAL PUBLICATION

Patient Name: _____

Age:_____

Address:_____

Hospital/Institution: _____

Diagnosis (optional): _____

I hereby consent to the taking and use of my clinical photographs/images for educational, scientific, and professional purposes.

I understand and agree that:

1. My photographs/images may be used for:
    - National Myositis Meet image competition
    - Educational presentations
    - Medical teaching and training materials
    - Scientific publications, atlases, conference proceedings, and related educational resources
2. Reasonable efforts will be made to protect my identity. However, complete anonymity cannot be guaranteed, especially if facial or other identifying features are visible.
3. The images may be published in print and electronic formats, including websites, online educational platforms, and digital archives.
4. I understand that once images are published electronically, they may be viewed by individuals worldwide and may be difficult to completely withdraw.
5. Refusal to provide consent will not affect my medical care in any way.
6. I may withdraw consent before publication or public presentation by notifying the treating physician/institution in writing. After publication, withdrawal may not be possible.

I confirm that:

- I have read and understood the above information.
- I have had the opportunity to ask questions.
- I voluntarily give my consent.

Patient Name: _____

Signature/Thumb Impression: _____

Date: _____

For a Minor Patient

Parent/Legal Guardian Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Witness

Name: _____

Signature: _____

Date: _____

Treating Physician

I certify that the purpose and implications of this consent have been explained to the patient/guardian.

Physician Name: _____

Signature: _____

Date: _____