Patient Consent Form

Date: DD/MM/YY

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 Journal of Basic and Clinical 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: [ ]