**Patient Consent for Publication**

This is to state that I authorize the release of my medical information, pictures of radiologic imaging, pathologic slides, and information regarding any eye lesions.

I confirm that I have reviewed all the materials related to myself, and I give my full permission for the publication, reproduction, broadcast and other use of photographs, recordings and other audio-visual material of myself (including of my face) and textual material (case histories) to be reported in a medical publication.

I understand that my name and initials will not be published and that efforts will be made to conceal my identity, but that anonymity cannot be guaranteed. I give permission for images of my face or distinctive body markings to be published and recognize that I might therefore be identifiable.

I recognize that I have the right to reject or consent to publication of my free will. I understand that I will have no disadvantage in ongoing medical and surgical treatment if I were to reject publication.

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*Name of the Patient Patient’s Date of Birth*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient or Legal Guardian Signature Date*

* In case of legal guardian, what is your relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Son/Daughter/Grandchild)
* Why is the patient not able to give consent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Underage/Deceased/Incapacitated)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Corresponding Author Signature of Corresponding Author*

**KJO 논문 투고를 위한 진료영상제공 환자 동의서**

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나는 동의를 거부할 권리가 있다는 사실과 동의거부에 따른 불이익이 없다는 것을 주치의로부터 듣고 이해하였습니다.