**PUBLICATION APPROVAL FORM FOR IDENTIFYING CLINICAL IMAGES**

I hereby give my consent for photographs/images of my face or distinctive body markings, or other clinical information relating to my case to be published in the Archives of Rheumatology.

I understand and I don’t approve/accept

I understand and acknowledge that

* I have a right to refuse to sign this form, and I acknowledge that refusing to give consent will not affect my treatment anyway.
* I have read this form, and the content has been explained to me in detail.
* (If the patient or the legal guardian is not fluent in English) The form and the content has been explained to me in my vernacular language before obtaining consent.
* The images/videos/models/x-rays of me will be published in the Archives of Rheumatology with/without adequately masking my identity.
* My name and initials will not be published in the journal.
* Even though my name will not be published in the article, I acknowledge that I might be identifiable.
* I cannot revoke this consent once I have signed this consent form.

*Name of the patient*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of the doctor*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

If the patient or subject is under 18 years old, a parent or legal guardian must consent on behalf of the minor.

*Name of the parent or legal guardian*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Relationships to minor patient/subject*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of the Doctor*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of the doctor*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of the parent/legal guardian*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Name of the Translator*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of the Translator*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*