**PATIENT CONSENT FORM**

Patient’s consent for the publication of material relating to him or her in

**Clinical and Experimental Pediatrics**

**Description of article, content or photograph (the “Material”):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of author submitting the Material:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Corresponding author’s affiliations and address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Manuscript number (if known):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by the patient: I give my consent for all or any part of the material referenced above to appear in publications of The Korean Pediatric Society (“Society”) in any media worldwide, including Clinical and Experimental Pediatrics and any derivative works or products. I understand that the Material may depict my medical conditions.

I understand that:

* My name will not be published with the Material by the Society and the Society will endeavor to maintain my anonymity. However, despite the Society’s best efforts, I understand that it is possible that someone may recognize me from the images and/or accompanying content.
* I have reviewed (OR I have been offered the opportunity, but I waive my right to review) all materials (photographs, video, or audio files) in which I am included that will be published.
* The use of the Material relating to me may include, without limitation, publication in the printed and electronic editions of Society publications, on websites.
* I grant and release to the Society all rights, title, and interest that I may have in the Material. I understand that I will not receive, and am giving up any claim to receive, any payment or royalties in connection with the use of the material

**PATIENT:**

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you are not the patient, what is your relationship to him/her*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_