CONSENT FORM

A/1324/4/8

The author who submits a manuscript involving the patient’s image(s) and/or information must submit a completed/signed consent form. The form should be attached or included in the submission of the manuscript to the system or can be sent via e-mail (omj@omsb.org) as a PDF scanned copy or clear image. (Please attach the image(s) included in this consent)

Manuscript title: ________________________________________________________________

Description of image(s)/other material to be published about the patient: ___________________

__________________________________________________________

Patient’s name: ________________________________________________________________

Kin’s name (if the patient is a minor or unable to sign): ______________________________

Relationship with the patient: __________________________________________________

Consent statement

I, ____________________________________________ [patient’s/kin’s printed full name], give my consent to ___________________________ [author’s name] to publish the information/image(s) about me/my relative in Oman Medical Journal.

I confirm that I am fully aware of all the images or details of me/my relative that is used in the manuscript and that I have read and approved it.

The following were explained and discussed with me.

1. Though my/patient’s name is not included, anonymity will not be guaranteed.
2. I have the right to withdraw my consent as long as the manuscript is not yet accepted for publication, but once the manuscript is accepted, withdrawal of consent will not be possible.
3. Once the manuscript is accepted and published, the copyright of the images belongs to the publisher. If other authors will seek permission to use the image as part of their publication, the publisher has the right to grant it according to CC-BY-NC 4.0 Creative Commons license.
4. My/patient’s image(s) or information will be published online and will be available to all the readers.
I agree with the above, and I accept the responsibility for completing this document and attesting its validity.

**Patient**

__________________________  ________________________
Signature                  Date

E-mail address: ________________________________  Phone number: ________________

**Kin (if the patient is minor or unable to sign)**

__________________________  ________________________
Signature                  Date

E-mail address: ________________________________  Phone number: ________________