Patient Consent Form

Patient Photographic Authorization, Release and Discharge

I, _____, give my consent and authorize the photograph(s) and clinical information featuring my likeness to be published in *The Journal of International Medical Research* by physicians from West China Hospital. I understand that such imaging records may be published by any party acting under the license and authority of *The Journal of International Medical Research* in any print, specifically including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses and Internet websites, for the purpose of informing the medical profession or the general public. I further understand that the imaging records shall become the property of *The Journal of International Medical Research*. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive.

I grant this consent as a voluntary contribution in the interest of public education and certify.

I have read the above Authorization, Release and Discharge and fully understand its terms.

Patient _____ Date 2019.12.1

WITNESS/PHYSICIAN:

_____

I have read the above Authorization, Release, and Discharge and fully understand its terms.

I am authorized to sign this consent on behalf of the patient.

Parent/Guardian_____ Date _____