**CONSENT TO PUBLICATION OF MATERIAL ABOUT THE PATIENT**

|  |  |  |
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|  |  |  |
| ***Name of patient in English*** *(BLOCK LETTERS)* |  | ***Name in Chinese*** |
|  |  |  |
| ***Place*** |  | ***Date*** |

**To be read and signed by both parents / surviving parent of the patient (if younger than 18 years) in the presence of a witness:**

In connection with the medical services that are being rendered by Dr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to

the above-named patient, I/we consent that photographs/videos may be taken of the said patient or of parts of his or her body and published under the following conditions:

1. The photographs/videos may be taken only with the consent of the above-named physician and under such conditions and at such times as may be approved by him or her.
2. The photographs/videos shall be taken by the above-named physician or by a photographer / video shooter approved by him or her.
3. The photographs/videos shall be used for medical records and if in the judgement of the above-named physician, medical research, education or science will be benefited by their use, such photographs and information relating to this case regarding the above-named patient may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purposes that the above-named physician may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use the patient shall not be identified by name.
4. The aforementioned photographs/videos may be modified or retouched in any way that the above-named physician, at his or her discretion, may consider appropriate.

I/We warrant by my/our signature(s) below that we are the parents / I am the surviving parent (delete as applicable) of the above-named patient, and that he or she is \_\_\_\_\_\_ years of age.

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| ***Name of patient’s father (BLOCK LETTERS)*** |  | ***Signature of father*** |
|  |  |  |
| ***Name of patient’s mother (BLOCK LETTERS)*** |  | ***Signature of mother*** |
|  |  |  |
| ***Signature of witness*** |  | ***Date signed*** |
|  |  |  |
| ***Signature of physician*** |  | ***Date signed*** |