SANATORIUM MEDICAL JOURNAL
PATIENT CONSENT FORM

I, _____ [insert full name], hereby give my consent for information about MYSELF / MY CHILD OR WARD / MY RELATIVE [circle the applicable option] related to the subject matter described above ("the Information") to be published in "Sanatorium Medical Journal" and its associated publications.

I have reviewed and approved the material intended for submission to the journal.

I acknowledge and understand the following:

1. The Information will be published without revealing my name, and "Sanatorium Medical Journal" will take all reasonable measures to maintain my anonymity. However, I acknowledge that complete anonymity cannot be fully assured. There is a possibility that someone, such as a healthcare provider who treated me or a family member, may recognize me.

2. The content may be edited for clarity, language consistency, and formatting without changing its intended meaning.

3. The Information may be published in "Sanatorium Medical Journal", which is circulated internationally. While the primary readership comprises medical professionals, the content may also be accessed by non-medical individuals, including journalists and researchers.

4. The Information will be accessible on the journal's official website

5. The Information may also be included, in full or in part, in other materials or publications issued by "Sanatorium Medical Journal" or any other publishers licensed by the journal. This may involve publication in English or other languages, in print, digital formats, or any other medium now or in the future.

6. "Sanatorium Medical Journal" will not permit the Information to be used for advertising, promotional purposes, or in any misleading or inappropriate context.

7. I retain the right to withdraw my consent at any time before publication, but once the Information has been finalized for publication ("gone to press"), revocation will no longer be possible.

By signing below, I confirm that I have read and understood the terms of this consent and willingly authorize the publication of the Information as outlined above.

Patient/Guardian Name: _____

Relationship to Patient (if applicable): _____

Signature: _____

Date: _____

Witness (if applicable): _____

Signature: _____

Date: _____