Case Report/Case Series entitled ……………..............................................……………………………………………………..…………..

…………………………………………………………………………………………………………………………………………………………………………………

Signed Date ............ Month ............................ Year ...............

Patient’s name ......................................................................................................................................

I have been informed and understand the following:

* The Case Report/Case Series will be published without my/the patient’s name or identification directly attached; however, I understand that complete anonymity cannot be guaranteed. It is possible that somebody somewhere may recognize the patient.
* The Case Report/Case Series may contain my/the patient’s medical condition, injury, disease prognosis, and treatments that I have/the patient has, had, or may have in the future. However, only essential data for the purpose of Case Report/Case Series per necessity will be published.
* The Case Report/Case Series may be published for an academic purpose in print, in digital formats, or in any other formats via multiple channels and may be linked to the public press or other social media/ channels, including marketing channels.
* I/the patient will not receive any financial benefits from publishing the Case Report/ Case Series.
* I/the patient can withdraw my consent without affecting the standard treatments the patient should receive for the patient’s medical conditions. However, I/the patient can withdraw the consent at any time but before publication. Once the Case Report/Case Series is in any publication process, the withdrawal of the consent is not possible per se.
* This consent form will be securely and confidentially stored by The Institutional Review Board, Faculty of Medicine, Chulalongkorn University, in accordance with the law, for no longer than the necessary period. Personal data provided in this form will be used and stored in accordance with Thailand's Personal Data Protection Act 2019.
* We may be required to pass on your consent form and the patient’s personal data to the third party, including the publisher that is unrelated to the activities involving you without your explicit consent. In doing so, we will work to ensure that receiving organization is in a country that has substantial personal data regulations and privacy policy in place and is certified by the Personal Data Protection Committee.

Where this consent relates to the Case Report/Case Series, I have/the patient has had the opportunity to comment or question on the Case Report/Case Series, and I am satisfied that the comments or questions, if any, have been addressed properly and mannerly by the researcher.

**Please tick boxes to confirm the following:**

1. The accessibility of medical records

[ ] I, the undersigned, give my consent for the accessibility of my/the patient’s medical records in the process of the Case Report/Case Series preparation and publication.

1. The use of the patient’s images/photographs.

[ ] I, the undersigned, give my consent for taking and publishing the patient’s images/photographs in the Case Report/Case Series.

1. The Case Report/Case Series in the Thai version

I, the undersigned, would [ ] like to [ ] like not to read the Case Report/Case Series before the publication submission.

1. Consent to contact

I, the undersigned, [ ] allow [ ] not allow the accessibility and use of my contact details, including address, phone number, or other channels, to reach me/the patient.

I confirm that I have carefully read and understood all the aforementioned information. Moreover, I am legally entitled to give the consent, and I have signed the document to give my consent to publish the Case Report/Case Series.

This document is signed by ................................................................................................................................................

Print name: ..............................................................................................................................................................................

Relationship to the patient (if the patient not signing this form): ...............................................................................

NOTE: If the patient/study participant is a minor (i.e., less than 18 years of age) or cannot provide informed consent for publication, this must be signed by their parent or legal guardian.

NOTE: If the patient/study participant is deceased, this must be signed by their next of kin.

Date ............ Month ............................ Year ...............

In case of the fingerprint signatures of the patient/their representative

Witness 1: .............................................................................................................

(Print name: …………………………………………………………………………………………….)

Witness 2: .............................................................................................................

(Print name: …………………………………………………………………………………………….)

Date ............ Month ............................ Year ...............

The researcher confirms that all necessary information of the Case Report/Case Series, including research objectives, possible risks, and benefits of involving in the publications, have been fully explained to the patient or their representative,

Details of the person who has explained and administered the form to the patient or their representative.

The researcher's signature: ...................................................................................................................................................

Print name: ..............................................................................................................................................................................

Date ............ Month ............................ Year ...............