Informed consent form for the publication of personal information

I hereby give my consent for all material from the medical record, images, and other information concerning the patient mentioned below to be published in a medical journal or presented at a medical congress, as deemed appropriate by the authors, for scientific and/or educational purposes.

Patient's name: ……..…….. Age: …….

I understand that the patient's name will not be published and that every effort will be made to preserve anonymity in the text and images. However, I also understand that complete anonymity cannot be guaranteed.

This authorization includes publication in English and its translation into Spanish, in print, in electronic format on the journal's website, and in any other format currently used or that may be used in the future by the scientific journal.

I acknowledge that the journal is intended for physicians, but may also be read by non-specialist audiences. I may revoke my consent at any time prior to publication; however, once the information has been prepared for publication ("in press"), it will no longer be possible to withdraw consent.

By signing this document, I declare to the relevant person or institution that I have understood and approved the above statements and that I have received a copy of this form.

The participation of minors and their responsible adults in the consent process will be adapted to the regulations on the autonomy of children and adolescents in each country.

*** For Argentina, depending on the patient's age, the person giving consent will be:**

- Age 16 years or older: the patient.
- Age 13 years or older but younger than 16 years: the patient, with the documented assistance of their parents/legal guardian.
- Age 8 years or older but younger than 13 years: parents/legal guardian, with the patient's documented assent.
- Age 8 years or younger: parents/legal guardian.

Person giving consent*: …… Age: …..……..

ID number: ……..……..… Relationship to the patient (if applicable): ……

Signature: ……... Date: ……

Person assisting/assenting*: …… Age: …..……..…….

ID number: ……..… Relationship to the person giving consent: ……..……

Signature: …… Date: ……..

Healthcare provider: ……..……..…

Signature: ……... Date: ……