Patient Consent Form for Publication

For a patient's consent to the publication of information about them in Archives of Pharmacy Practice.

SUBMISSION DETAILS

Name of person described / shown

Subject matter of photograph or article

Journal Name

Manuscript Number

Title of Article

Corresponding Author

STATEMENT OF CONSENT

I, (full name), give my consent for the information described below ("the Information"), relating to the subject matter above, to appear in Archives of Pharmacy Practice.

This information relates to:

- ☐ Myself
- ☐ My child or ward
- ☐ My relative

I have seen and read the material to be submitted to Archives of Pharmacy Practice.

I UNDERSTAND THE FOLLOWING

1. The Information will be published without my name attached, and the journal will make every attempt to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed - it is possible that somebody, somewhere, may identify me.
2. The text of the article may be edited for style, grammar, consistency, and length.
3. The Information may be published in Archives of Pharmacy Practice, which is distributed worldwide and may be accessed by medical and academic professionals as well as non-specialist readers, including journalists.
4. The Information may also be used, in full or in part, in authorized print, electronic, translated, archived, and other publication formats of the article, now and in the future, in accordance with the journal's publication policies.
5. Archives of Pharmacy Practice and its publisher will not permit the Information to be used for advertising or packaging, or to be used out of context.
6. I can revoke my consent at any time before publication, but once the Information has been committed to publication ("gone to press"), it will not be possible to revoke consent.

SIGNATURE

Signed (type full name as digital signature)

Date