# CONSENT TO PUBLICATION OF MATERIAL ABOUT THE PATIENT

PLEASE USE BLOCK CAPITALS

Patient name.....Salil Saha.....

## PATIENT CONSENT

I hereby confirm that I give consent for the **material** set out on the attached request form to be published.

It has been explained to me that the material has educational value. I therefore consent to the material being shown to appropriate professional staff (i.e. health care professionals, including students) and published in educational publications, journals, textbooks in any form or medium (including all forms of electronic publication or distribution) anywhere in the world without time limit. I also understand that it is possible that the material may be seen by the general public. All or any part of the material may be used in conjunction with other photographs, drawings, videotape images, sound recordings or other forms of illustration. I understand that efforts will be made to conceal my identity, but that full anonymity cannot be guaranteed.

I understand that I may view the material by arrangement with Dr. Nilanjan chaKraborty (ICMR virus unit). However, once the material is made available for research or teaching purposes (which shall include publication), I realise that recovery of the material may not be possible. I understand that no fee is payable by Dr. NchaKraborty or any other person for use of the material either now, or at any time in the future.

I confirm that the purpose for which the material may be used has been explained to me in terms which I have understood. It has been made clear to me that refusal to consent will in no way affect my medical care. I confirm that I am over 16 years old, of sound mind and that I am not signing under any form of duress.

**To be completed by the patient or parent/guardian, or next of kin if the patient is under 16 years of age, or deemed unfit to give legal consent.**

Full name: SALIL SAHA

Address: Abhirampur, Ausgram II, Burdwan, West Bengal, India.

Signature S. Saha Date: 13.07.2015

(Patient, parent/guardian or next of kin)

Signature S. Saha Date 13:07:2015

*Hospital details*
Calcutta Medical college and hospital, Department of General medicine, Kolkata - 700073, West Bengal, India.
Date: 13:07:2015.

# CONSENT TO PUBLICATION OF MATERIAL ABOUT THE PATIENT

PLEASE USE BLOCK CAPITALS

Patient name.....Md. Kamran.....

## PATIENT CONSENT

I hereby confirm that I give consent for the **material** set out on the attached request form to be published.

It has been explained to me that the material has educational value. I therefore consent to the material being shown to appropriate professional staff (i.e. health care professionals, including students) and published in educational publications, journals, textbooks in any form or medium (including all forms of electronic publication or distribution) anywhere in the world without time limit. I also understand that it is possible that the material may be seen by the general public. All or any part of the material may be used in conjunction with other photographs, drawings, videotape images, sound recordings or other forms of illustration. I understand that efforts will be made to conceal my identity, but that full anonymity cannot be guaranteed.

I understand that I may view the material by arrangement with Dr. Nilanjan chakraborty (ICMR Virus Unit). However, once the material is made available for research or teaching purposes (which shall include publication), I realise that recovery of the material may not be possible. I understand that no fee is payable by Dr. N. chakraborty. or any other person for use of the material either now, or at any time in the future.

I confirm that the purpose for which the material may be used has been explained to me in terms which I have understood. It has been made clear to me that refusal to consent will in no way affect my medical care. I confirm that I am over 16 years old, of sound mind and that I am not signing under any form of duress.

**To be completed by the patient or parent/guardian, or next of kin if the patient is under 16 years of age, or deemed unfit to give legal consent.**

Full name: Md. Kamran

Address: Akrampur, Habra, North 24 Parganas
West Bengal, India

Signature Md. Kamran Date: 14.08.2015

(Patient, parent/guardian or next of kin)

Signature Md. Kamran Date 14.08.2015

*Hospital details*
Calcutta Medical college & hospital, Department of general medicine, Kolkata 700073, West Bengal, India.
Date: 13.07.2015