Patient Consent Form

This consent form should be retained by the corresponding author and should not be sent to *Infect Chemother* journals.

**To be completed by the corresponding author:**

Title of article, photograph, video, or audio:

Name of author submitting material:

Corresponding author's affiliations and address:

Manuscript reference number, if known (e.g. IC-19-001): *

**To be completed by the patient (s)/patients’ relatives or guardians:**

I give my consent for all or any part of this material to appear in print and online versions of *Infect Chemother* journals under an open access license.

I understand that:

- My name will not be published with the material and *Infect Chemother* will endeavor to ensure my anonymity. However, despite *Infect Chemother*’s best efforts, I understand that it is possible that somebody, for example members of my family or the health care staff who have looked after me, may recognize me from the image and/or the accompanying text.

- I have reviewed (OR I have been offered the opportunity, but I waive my right to review) all materials (photographs, video, or audio files) in which I am included that will be published.

- Use/re-use of my material may include (without limitation) publication, sharing and adaptation of the material in print and electronic editions of *Infect Chemother* journals, on websites, in sublicensed or reprinted editions (including foreign language editions), and in other works or products if proper accreditation/citation of the original publication is given.

- I cannot revoke this consent once I have signed this consent form.

Signed : ___________________________ Date : ________________

Print name: __________________________________________________________

*If you are not the patient, what is your relationship to him/her?*

Witness: ___________________________ Date : ________________