***Nutritional Foundations*: Student Journal of the Council on Nutrition of the American Chiropractic Association**

**Consent for Publication of Images and/or Case Information**

Title of submitted manuscript: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Author(s) name(s) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person/Patient to fill in items below:

I hereby give my consent for my image or other information relating to me to be reported in the above-named manuscript for consideration of publication in the *Nutritional Foundations*. I understand that this signed form will be submitted to the journal with the manuscript as evidence of my consent.

I understand that protected health information such as my name, identification number, billing information, address, etc. will not be published and that effortswill be made to conceal my identity, however, the journal cannot guarantee confidentiality once the case is published. Images, including distinctive body markings and/or diagnostic images, may be published.

I understand that the material may be published in *Nutritional Foundations* (both in print and electronically) and in products derived from the journal. As a result, I understand that the material may be seen by the public. I understand that I may revoke consent at any time before publication, but once the information has been published revocation of the consent is no longer possible. I understand that I will derive no financial benefit from publication of this paper.

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature (or signature of the person giving consent on behalf of the person/patient) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |

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| Only complete this section if you are not the person/patient. What is your relationship? (The person giving consent should be a substitute decision maker or legal guardian or should hold power of attorney for the person/patient.)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Why is the person/patient not able to give consent? (e.g., is the person/patient a minor, incapacitated, or deceased?) |

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