**Consent form for publication of pictures of patients**

Full Name:   
Nationality:   
Profession:   
National ID number:   
CPF (For Brazilians):   
Address:   
Legal guardian (if applicable):   
*(In case of incapacitation)* Degree of kinship: 

Name of physician: 

Object: Photographs of the GRANTOR(s) dated from  (describe photographs, including diagnosis). Through this document I authorize, free of charge, for unlimited time and in any territory, SOCIEDADE BRASILEIRA DE DERMATOLOGIA (BRAZILIAN SOCIETY OF DERMATOLOGY), registered in CNPJ/MF under the number 42174094/0001-65, to reproduce my image displayed in photographs, the object of the present authorization, to be published in the scientific journal entitled "Anais Brasileiros de Dermatologia" and in any platform and/or channel that the journal is published, without limit to the number of issues, and for all scientific and educational purposes not necessarily expressed here.

I herein state that I am aware that my facial traits may be visible, thus recognizable, in the picture to be published and used for all purposes above mentioned.

However, I do not authorize the inclusion of my name in any of the images to be used by the BRAZILIAN SOCIETY OF DERMATOLOGY for the purposes of this authorization.

Finally, I waive any rights related to the present authorization for use and publication of my photographs, exempting the BRAZILIAN SOCIETY OF DERMATOLOGY and its professional staff from any legal claims that could arise from my rights.

, 4/13/2020  
(Insert place and date on document)

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Signature:  
Name: 

Witnesses:

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name:   
National ID number: 

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name:   
National ID number: 

\* If the patient is a minor or unable to give written permission for any reason, the authorization should be granted by the patient’s legal guardian.