CONSENT FORM: **An Electronic Atlas of Human Malformation Syndromes in Diverse Populations**

Name of person described in article or shown in photograph:_____

Subject matter of photograph or article:_____

I_____[insert full name] give my consent for this information about MYSELF/MY CHILD OR WARD/MY RELATIVE [circle correct description] relating to the subject matter above ("the Information") to appear in **An Electronic Atlas of Human Malformation Syndromes in Diverse Populations and medical journal articles**. I have seen and read the material to be submitted to the National Institutes of Health (NIH) website and I understand the following:

1. The Information will be published without my name attached and the NIH will make every attempt to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after me if I was in hospital or a relative - may identify me.

The website is strictly a resource for medical professionals; the purpose of this website is to assist medical professions diagnose and treat malformation syndromes. Permission will be needed for photographs or other information to be used for other purposes, but may be seen by many non-doctors, including journalists.

The Information may also be used in full or in part in other medical publications by physicians responsible for website such as medical journals.

NIH will not allow the Information to be used for advertising or packaging or to be used out of context (for example, a photograph will not be used to illustrate an article that is unrelated to the subject of the photograph.)

I understand that I may refuse to sign this authorization and that my refusal to sign will not, in any manner, affect my ability to obtain medical treatment or participate in clinical research from my primary physician or the National Institutes of Health. I also understand that this authorization may be revoked in writing at any time.

_____

Signature of Patient, Parent, or Legal Guardian

_____

Signature of Physician or Designee