مؤتمر الرابطة العمانية للروماتيزم 2026

Oman Society of Rheumatology Conference 2026

Thursday-Saturday

23-25 April 2026

Muscat, Oman

Patient Authorization for Use of Photographs and Medical Images

I hereby grant permission for any photographs, video recordings, or medical images taken of me on ___________________ (*date*) by ________________________________ (physician/healthcare provider name) to be used by the **Oman Society of Rheumatology (OSR)**.

I understand that these materials may be utilized for professional, educational, scientific, or public awareness purposes, including but not limited to conferences, lectures, publications, digital platforms, social media, training activities, and other initiatives related to rheumatology and patient education.

I acknowledge that:

- My name and personal identifying details will not be disclosed in association with these materials unless I provide additional written authorization.
- While reasonable efforts will be made to protect my identity, certain images may contain distinguishing features that could make me recognizable.
- The materials may be shared with healthcare professionals, academic institutions, partner organizations, or the public in the context of education and awareness.
- Once released for educational or public purposes, the materials may be redistributed and may no longer be fully protected under applicable data privacy regulations.

I confirm that:

- This authorization is given voluntarily and without financial compensation.
- I have had the opportunity to ask questions regarding the use of these materials.
- I understand that I may withdraw this consent in writing prior to the publication or official release of the materials, were reasonably feasible.

By signing below, I confirm that I have read and understood the contents of this authorization and agree to its terms.

Patient Full Name: ___________________________________

Contact Information: __________________________________

Signature: _________________________

Date: _________________

If the patient is under 18 years of age:

Guardian/Parent Full Name: ____________________________

Relationship to Patient: ______________________________

Contact Information: __________________________________

Guardian Signature: _________________________

Date: _________________