CONSENT TO MEDICAL PHOTOGRAPHY

Patient Name: _____ DOB: _____

Your doctor has determined that it is necessary or helpful to obtain a photograph / recording of your condition to assist with treatment. This will form part of your medical record and will be held and used strictly in accordance with your wishes which can be defined below. Photographs will only be taken and used with your consent, which can be refused or limited by you and you can also withdraw this or change it in the future. You will have the opportunity to view all images or recordings prior to signing this consent. Please sign this form once you are happy that all of the above aspects have been explained fully to you.

	Yes	No
I consent to photographs being taken for my medical records		
I consent to the photographs being made available to other clinicians involved in my treatment		
I consent to my photographs being used for teaching purposes providing these are anonymised		
I consent to my photographs being used for another specific purpose (please define)		
I require the following restrictions to be applied to my images/ recordings:		

Signature of Clinician Accepting Consent:_____

Name of Clinician: _____

Signature: _____(Patient) Date: _____

Signature:_____(Parent/Guardian/Carer)