Medical Practice

Patient Clinical Photography Consent Form

Patient Name (First, Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and consent to the photography of the area(s) of my body as listed below:

|  |  |  |
| --- | --- | --- |
| - | - | - |
| - | - | - |
| - | - | - |
| - | - | - |

I **understand** and **consent** to the use of these photographs for the following purposes:

|  |  |  |
| --- | --- | --- |
| **Monitoring**, **diagnosis** and **treatment** of any skin or skin-related issues I may have or develop | * **YES** | * **NO** |
| **Teaching** of health professionals (e.g. doctors, nurses) by way of printed or electronic means | * **YES** | * **NO** |
| **Research publication** to increase health professional awareness and education of skin-related issues (e.g. in medical journals, electronic publications or information booklets) | * **YES** | * **NO** |
| **General publication** to increase patient awareness and education of skin-related issues (e.g. leaflets or electronic publications) | * **YES** | * **NO** |

Other specified purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I **understand** that I am free to **withdraw** my consent to the above purpose at any time, although in the case of images used for teaching or publication, it may be impossible to totally remove these from public viewing.

I **understand** that refusal or withdrawing of consent to any of the above uses will have no effect on the medical care that I receive.

Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian Name (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Name (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_