Photograph / Video Consent Form

Patient name _____ Date / /

I consent for medical photographs and/or video recordings to be made of me or my child (or person for whom I am legal guardian).

By consenting to these medical photographs and/or video recordings I understand that I will not receive payment from any party. Refusal to consent to photographs and/or video recordings will in no way affect the medical care I will receive.

I consent for these photographs and/or video recordings to be kept on file by my practitioner and in some cases used for promotional and advertising purposes. These photographs and/or video recordings could be used in printed or digital format. I understand that the image may be seen by members of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognise me.

I understand that the images and/or video recordings may be kept permanently after publishing however, I can ask for the photographs and/or video recordings to stop being used at any time.

By signing this form below I confirm that this consent form has been explained to me in terms I understand.

If I have any questions or wish to withdraw my consent in the future I may contact:

_____

Signed: **(Patient / Persons with parental/legal responsibility)**

_____

Relationship to patient (if applicable)

_____

Date:

/ /

Practice Details
This is who the consent is held by

_____