Details

Social Media Consent Form

Patient name _____ Date / /

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used for social media as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

I consent for these photos to be used on social media. 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.

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) Date: / /

Relationship to patient (if applicable)

Practice Details

This is who the consent is held by