Orchard Croft Medical Centre
Consent form 6

Form for patients to consent to photography for clinical purpose

Patient details (or pre-printed label)

Patient's surname/family Name_______________________________________

Patient's first names ____

Date of birth ____

Responsible health professional _____________________________________

Job title____

NHS number (or other identifier) ____________________________________

☐ Male ☐ Female

Special requirements____
(eg other language/other communication method)

I have explained that the pictures and photographs made for clinical purposes will form part of your records. They will only be used to aid clinical examination or to evaluate treatment and will not be used in publications, training events, clinical audit or research unless the patient has given permission to do so.

Doctors signature _______________________ Date ____________________

Name (print) ____

I confirm that it has been explained to me why the photograph/video recording is being taken and;

☐ Yes, I agree to pictures being taken as part of the clinical examination and treatment.

☐ No, I do not agree to pictures being taken as part of the clinical examination and treatment.

Patients signature __________________________ Date __________________

Name (print) ____