Kew Medical

MEDICAL · COSMETIC · WELLNESS

Patient Consent – Photography

NAME _____ DOB ____ / ____ / ____

We seek your consent for clinical photography. Clinical photographs can be valuable in tracking your progress and recovery, in evaluating the effects of your treatment and the passage of time, for communicating with other health care professionals who are involved in your treatment, and for further education and clinical research.

Please read this form carefully, complete it according to your preferences and sign below.

PATIENT DECLARATION

I consent to clinical photographs and/or video being taken as part of my treatment. I agree that the images may be (please tick according to your preferences):

The medical record used for teaching of medical, nursing and healthcare staff and during initial consultations for the purpose of medical education. ☐ YES ☐ NO

For the purpose of medical education I acknowledge that:

+ I have read the above information and have received an explanation about what clinical photographs will be taken and why.
+ I am not obliged to agree to clinical photography being taken as part of my treatment but in some circumstances my failure to do so may impact on the quality of treatment that can be provided to me.
+ I understand that my photographs will not be used for any purpose other than set out above without my consent.

SIGNED _____ DATE ____ / ____ / ____

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