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Medical Photography Consent Form

PATIENT CONSENT

I,

_____

First name *Last name* *dob*

consent to medical images and / or video being made of me or my child /dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(*Please tick below to show consent*)

	Yes	**No**
… **placed in my medical record for future treatment**	____	____
… **electronically emailed to my treating health professional**	____	____
… **used by health professionals for education and training**	____	____
… **used in paper or electronic health publications**	____	____
… **used in commercial broadcast**	____	____
… **used in marketing materials**	____	____

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Patient/Parent or Guardian: Date:

_____ _____
Signature of Doctor/Health Professional/Staff: Date: