Mid Essex Hospital Services NHS Trust **NHS**

CLINICAL PHOTOGRAPHY
Patients' Consent/Request Card

*** IMPORTANT** for legal reasons, highlighted fields must be completed

* NHS Number ______________________________

* Patient Number ___________________________

* Surname ________________________________

* Other Names ____________ *Date of Birth ___/___/___

* Diagnosis _______________________________

* Consultant/Clinician requesting photography ________

* Patient's Consultant ______________________

* Area of body to be Photographed ______________

*I confirm that I (delete as necessary: Consultant; Surgeon: Dr; Nurse) have explained to this patient, who is under my care, why I have taken the photographs associated with this Consent, and what will happen to them in the future

Signature __________________ Date ___/___/20___

I have been informed about the clinical photography procedure and **agree** to the procedure being carried out. I understand that these photographs are recorded on a digital format and will be stored safely on a secure database and server. I understand these photographs form part of my medical records

Signature ______________________ Date ___/___/20___

Patient aged over 16/competent child/parent/guardian (delete as appropriate)

In addition to use in medical records **I agree** that my clinical photographs be available for clinical teaching purposes.

Signature ______________________ Date ___/___/20___

Patient aged over 16/competent child/parent/guardian (delete as appropriate)

I agree that my clinical photographs be available for future research and/or publications and understand that, if selected, I will be contacted to give **my specific consent** for my clinical photographs to be published in a medical journal or publication

Signature ______________________ Date ___/___/20___

Patient aged over 16/competent child/parent/guardian (delete as appropriate)

I agree that my clinical photographs be available to view by patients receiving similar treatment to myself and where viewing these photographs may aid their treatment process

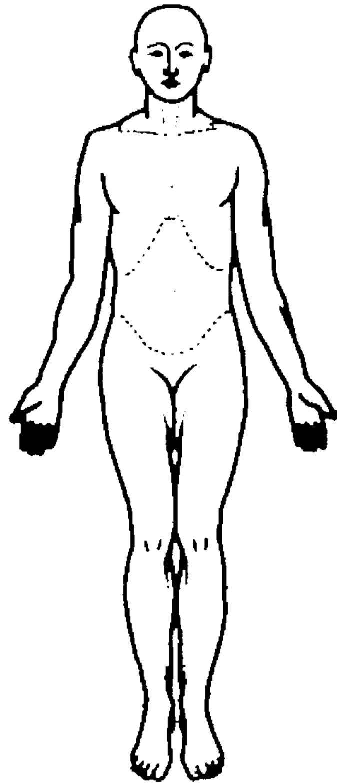
Signature ______________________ Date ___/___/20___

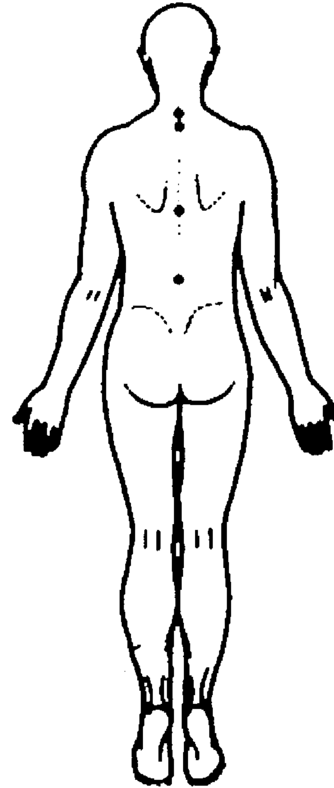
Patient aged over 16/competent child/parent/guardian (delete as appropriate)

Notes:

*Date of photograph	*Job number	*No of images taken	*Name of photographer	*Location of photograph	*Checked by

PLEASE INDICATE
AREA TO BE PHOTOGRAPHED





Notes

Print item reference: 02:16:10-2