CONSENT FOR WOUND PHOTOGRAPHY

NAME:_____ CHI NO._____

Address:_____ Date of Birth_____

_____

Wound Type/Presenting Problem_____

Informed Patient Consent – to be completed by patient/relative/carer.

Clinical photographs form an important part of your medical records and every care is taken to ensure that only authorised staff involved in your care have access to them. There are three levels of consent available to you (A, B, C).

Your choice of consent level will not affect your treatment in any way.

Please tick or cross one box in every section	Agree	Disagree
A. Medical Records I consent to photographs being used for monitoring Treatment; a copy will be placed in my health records.	☐	☐
B. Teaching I consent to the photographs being used to teach medical, Dental, nursing and healthcare staff and students.	☐	☐
C. Publication I am happy to be contacted to give written consent if my images are requested for medical publications. A separate Form will need to be signed for each specific publication.	☐	☐

I confirm that I (CAPITALS)_____ consent to have a photograph taken. The purpose of this has been explained to me.
Date: _____

I understand that I have the right to withdraw consent at any time.

Sign (Patient) _____

Sign – Relative/Carer _____ Relationship to Patient _____

Address (if different from above) _____

I have fully explained to patient/carer the nature and purpose of this consent, including the different levels of consent and possible ways the photographs may be used.

Name _____ Designation _____

Signature _____ Date _____ Time _____