Consent to Photography

St George's University of London

AFFIX PATIENT LABEL

Name .....

Hospital number .....

Date of birth .....

We adopt a policy in line with Data Protection Act which gives you the right to control the future use of photographs (including video recordings) taken of you during the course of your medical treatment.

This consent limits the use to the purposes only specified by you the patient and should it be desired to use your photograph(s) in any other way, for example in a medical textbook or an online teaching resource, your specific permission will be sought to do so.

Please tick (ONE BOX ONLY) the consent you wish to provide

A ☐ I consent to photographs being taken for my personal **medical records**

or

B ☐ I consent to photographs being made available for **medical records** and **teaching** in the healthcare context both in this Trust and other medical teaching establishments

SPECIAL REQUEST

C ☐ I consent to my photographs being published for the specific listed purpose described below. This consent does not extend to any further publications / display without my specific consent. Please ensure the full address is included with the above patient details and that the specific publication is indicated below

Exact details of publication .....

.....

Clinician .....

Department .....

Signature of Patient / Parent / Guardian

..... **Date** .....

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