Consent for Clinical Photography

Patient's name: ____

Practitioner's name: ____

Treatment(s): ____

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This is your consent to having clinical photographs taken for the purpose of treatment diagnosis and results. These will be kept absolutely confidentially and securely and will only be used in ways that you have given consent for.

I understand that I will be recognisable in the photographs but that no personal details such as name, address, or date of birth will be released by the practice without my prior agreement.

I understand that I can withdraw my consent at any time by contacting the practice.

I expressly authorise my photographs to be used for the following purposes:

	(Patient initials) To be kept securely in my confidential clinical records
	(Patient initials) To be stored securely on a digital device for the purpose of my confidential clinical records
	(Patient initials) To be used internally at the practice to show patients our high standards of treatment and the results that we achieve
	(Patient initials) For practice marketing such as brochures / website / advertisements
	(Patient initials) Other (specify) ___________________________________

Patient's signature: Date

Practitioner's signature: Date

For further details about how we process your personal information please see the Privacy Notice on our website or contact us by email or telephone.