.the derm studio.

Patient Consent for Medical Photography

Patient Name: _____
Date: _____

I consent for medical photographs to be taken of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical records, or to demonstrate teaching points to other patients or public through electronic publishing. I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

Choose One Option

1. I consent for my photographs to be used for medical records and in electronic publications. I understand that the image may be seen by members of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

☐ check here if you agree to the above option, but only provided that no identifying information be revealed (i.e. no photos of face)

_____(Signature) _____(Witness)

2. I agree to use of my image for medical records ONLY:

_____(Signature) _____(Witness)

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