CLINICAL PHOTOGRAPHY CONSENT FORM

***Patient Information***

**Patient’s Name: …………………………………………………………**

**Patient’s Address: …………………………………………………………**

**…………………………………………………………**

**…………………………………………………………**

**Patient’s D.O.B: …………………………………………………………**

**Purpose of Photography - Please indicate Yes/No with a X**

**I consent to my images:**

**RECORDS**

being stored in my personal clinical record………………………… Yes No

**TEACHING**

being made available for healthcare teaching

within Kingsmills Medical Practice ………………………………………… Yes No

**REFERRAL**

being used for the purpose of describing a skin

problem to a hospital specialist by electronic

delivery through secure access ……………………………………………… Yes No

**I agree to have photographs taken for the above marked purposes and note that my permission will be sought if the pictures are to be used for any other purpose.**

Patient’s signature: …………………………………………………….

Date: ……………………………………………………………………………

Please attach your consent form with your photos and send to

[nhsh.gp55817-reception@nhs.scot](mailto:nhsh.gp55817-reception@nhs.scot)