CLINICAL PHOTOGRAPHY / DIGITAL IMAGE / VIDEO AUDIO RECORDING

This consent form is to be used to gain consent for taking any clinical images for clinical reasons to support and inform assessment and/or a treatment plan.

Patients Full Name _____ NHI Number_____

Date of Birth_____ MALE □ FEMALE □

Address_____

PATIENT SECTION

The health professional will have explained why they need to take an image/recording to best meet your health needs. If you have any further questions, please ask as we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

PATIENT AGREEMENT

I understand the benefits and risks as described to me by the health professional I understand that if I do not wish to be photographed/ have a video or audio recording this is my choice I understand the recorded information will be used to support my treatment.

□ I consent to _____being stored safely with my health records (health professional to state type of image that is being recorded) o I do not consent for any image/recording to be taken

Signature _____Date _____ Full name of Legal Guardian if a child_____

A witness should sign below if the patient is 'physically unable' to sign though can still give consent. If patient cannot give consent health care professionals would need to follow best interests.

Witness Signature …… Date …… Name (PRINT) ……Relationship ……..

All Skin logics/ Hamilton Lake Clinic policies and procedure relating to the safe storage of clinical documentation must be followed. Staff must only use cameras and equipment that has been approved and supplied by Skin Logics/ Hamilton Lake Clinic. Personal mobile phones must not be used.

CONFIRMATION OF CONSENT

On behalf of the team treating the patient, I have explained that the recorded images will support assessment and treatment and will be shown to the patient, should they choose to see them, to help explain clinical treatment and or progress with care plan goals. I have explained the risks and benefits of making a recording. I have confirmed with the patient that he/she has no further questions at this time.

Diagnosis and reason for image:- (clinician to complete including body area to be photographed) ……..

……
……
……

Signed …… Date …….

Name (PRINT) …….. Job Title ……..

Base ……..

IMAGE/RECORDING TO BE RETAINED IN/WITH PATIENTS RECORDS

- Rationale for taking image and that a consent form has been completed needs to recorded in the patient's health records to promote continuity of care in accordance with the Skin Logics/ Hamilton Lake Clinic Clinical Protocol for Photography and Video Recording of Patients.

- Any electronic storage system that is in use in your team or service must have been approved by the Hamilton Lake clinic/ Skin Logic Management to ensure all Information Governance standards are in place to protect the safe storage of patient related information and ensure there is a full set of contemporaneous health records

- Privacy and dignity must be maintained at all times