HSC Belfast Health and Social Care Trust
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Consent for Medical/Dental Photography/Video

Surname: _____

First name: _____

Consultant: _____ Ward: _____

H+C Number: _____

DOB: _____ Check identity

Please read this form very carefully. If there is anything that you do not understand, ask the staff looking after you to explain it.

You have the right to refuse to have images taken and this will not affect your treatment in any way.

You may withdraw consent at any time, even after images have been taken. However if the images have been published in a book, journal or magazine it will not be possible to withdraw them. You can choose what your images will be used for by initialling below.

◯ Male ◯ Female

Special requirements: (language or other) _____

Please indicate what we can use your recording for	**INITIAL HERE** *(patient or patient rep)*
1. To document my current clinical condition, or symptoms, or a particular aspect of my treatment in my healthcare records (to show how I look or how I may have changed).	
2. For teaching, examination or other educational purposes. The images may be used to teach students or other doctors or nurses, both within the hospital and elsewhere.	
3. For publication in printed materials such as medical or nursing journals, educational articles or booklets. These will be available to the public as well as other doctors and nurses.	
4. For publication on the Internet for educational purposes only. This means that other professionals and in some cases members of the public may see the images.	

The nature of the photographs/video to be recorded and the intended use of the photographs/video has been fully explained to me and I consent to photographs and/or video recordings being taken of me, my operation or procedure for the purposes initialled above.

Patient signature: _____ Date: _____

Clinician: (FULL NAME) _____ Job title: _____

Hospital site or community location: _____

Photographs/video taken by: _____

Please fill in Medical Photography Request Form below if Medical Photography is being requested

Parental agreement for photography or video of a child/young person, or for a representative agreeing consent on behalf of a patient.

I agree to the photography/video described on this form and **I confirm that I have authority** to provide this consent.

Signature: _____ Date: _____

Full name: (PRINT) _____ Relationship to patient: _____

This section **MUST** be completed where a patient or representative is unable to provide consent and the Clinician deems it to be in the patient's best interests for the photographs/video to be recorded.

Clinician: (FULL NAME) _____ Job title: _____

Reason for photograph/video: _____

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Medical Photography / Video Request

Consultant: _____

Signed: _____

Ward/Unit/OPD: _____ Diagnosis: _____

Please indicate details of request

Details of request:

_____

_____

_____

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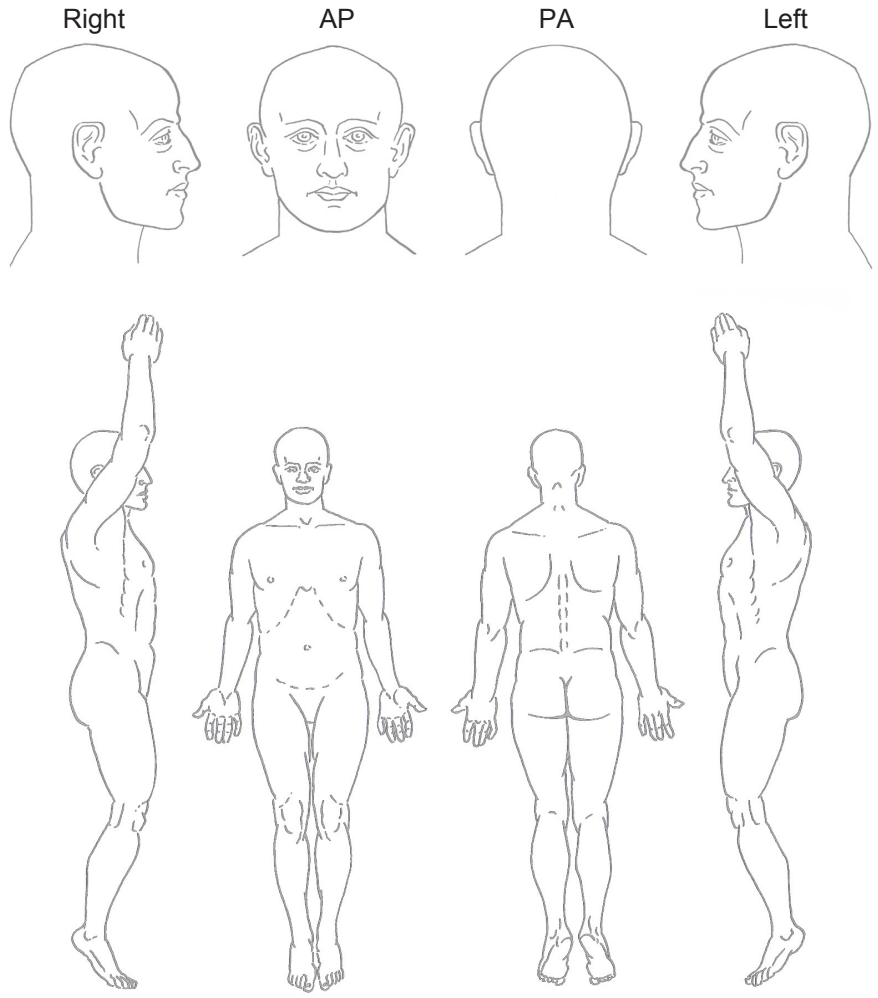

For Office Use

Site code: _____ *Eg. BCH, RVH, MIH, MPH*

WIP Folder No.

Inpatient ◉ New ◉
Outpatient ○ Old ○
Daycase ○

Photography ☐ **Output:** Prints ☐
Video ☐ Digital files ☐

Photographer's notes

Camera	Card	Images

Recorded by: _____

No. of views: _____

Date: _____ Time: _____

Location: _____

Comments: _____

Chaperone: Yes ○ No ◉ DNA ☐