Photographic Consent Form

Personal Details

Full Name: _____ DOB: _____

First and Middle *Last*

Consent and Signature

Clinical photographs are an important tool for the documentation of skin disease as well as progression and response to treatment.

Our doctor or nursing staff may request to take photographs during your appointment.

Your photographs will be taken on a camera solely used for this purpose and uploaded as soon as possible to your patient file or a mobile phone which uploads immediately to your medical record.

Your photographs, like the rest of your personal information, will be treated with the utmost respect and confidentiality.

3. Please tick the corresponding box if you consent to your clinical photographs being used in the following ways:

   ☐ Storage in your patient file at our clinic for documentation and monitoring. Photographs will be accessible only by authorised staff.

   ☐ For second opinion or expert assistance from another health professional in personal communication. This may or may not be de-identified as the case warrants.

   ☐ De-identified for second opinion or expert assistance from other health professionals at a panel, forum or clinical meeting.

   ☐ De-identified for use at meetings, workshops or other tutorials for health professionals for educational purposes.

   ☐ I <u>do not</u> consent to my photographs being taken.

You can withdraw your consent to any of the above at any time by calling or emailing:
myPRODERM Practice Co-ordinator
Ph: (08) 7087 0814
Email: reception@myproderm.com

4. Signature _____ Date of Signature ____ ____ ____

DD MM YY

Name of Parent / Guardian if applicable: