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CONSENT TO MEDICAL PHOTOGRAPHY

Patient Name: ______________________________________ DOB: _______________

Your doctor has determined that it may be in your best interest to obtain a photograph of your skin condition to assist with treatment. This will form part of your medical record and will be held and used strictly in accordance with your wishes which are defined below. Photographs will only be taken and used with your consent, which can be refused or limited by you. You can also change or withdraw this consent in the future. Please sign the form once you are satisfied that all of the above aspects have been explained fully to you.

	Yes	No
I consent to photographs being taken for my medical records so they may be used to identify lesions that are biopsied, should they require further treatment.		
I consent to the photographs being made available to other clinicians and clinical staff involved in my treatment.		
I consent to my photographs being used for teaching purposes providing they are anonymous.		
I require the following restrictions to be applied to my images:		

Signature: ___________________________________ (Patient) Date: ______________________
Signature: ____ (Parent/Guardian/Caretaker)