Medical Photography Consent Form

Patient Information

Full Name: ____

Date of Birth: ____

Contact Number: ____

Email Address: ____

Purpose of Photography

Intended Use:

☐ Diagnosis and treatment planning

☐ Medical education or research

☐ Patient records

Consent Options

☐ I consent to the use of my photographs for the stated medical purposes.

☐ I do not consent to the use of my photographs.

Additional Information

The photographs will:

- Be stored securely in the patient's medical records.
- Not be used for public purposes without further explicit consent.

Acknowledgment

By signing, I confirm that I understand the purpose and potential use of the photographs.

Patient/Guardian Signature: ________________ **Date:** ____________________

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