***Patient Information***

**Patient’s Name: …………………………………………………………**

**Patient’s Address: …………………………………………………………**

**…………………………………………………………**

**…………………………………………………………**

**Patient’s D.O.B: …………………………………………………………**

**Purpose of Photography - Please tick**

**I consent to my images:**

**Records**

being taken for my personal clinical records

**Teaching**

being made available for healthcare teaching

within Riverside Medical Practice

**Referral**

being used for the purpose of describing a skin

problem to a hospital specialist by electronic

delivery through secure access.

**I agree to have photographs taken for the above marked purposes and note that my permission will be sought if the pictures are to be used for any other purpose.**

Patient’s signature: -----------------------------------------------------------------------------

Date: ---------------------------------------------