**CROYARD MEDICAL PRACTICE**

**CLINICAL PHOTOGRAPHY REQUEST FORM**

**Patient Information**

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

**Patient’s Address …………………………………………………………………..**

 **…………………………………………………………………..**

 **…………………………………………………………………..**

**Patients DOB ………………………………………………………………………….**

**Purpose of Photography - Please mark box**

**I consent to my images:**

**Records**

being taken for my personal clinical records

**Teaching**

being made available for healthcare teaching

within Croyard Medical Practice

**Referral**

being used for the purposes 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 ……………………………………………………………………………………………………………………

Please complete and attach this form with your photos and send to: nhsh.gp55709-admin@nhs.scot