NORTHSIDE FAMILY DOCTORS

Medical Image Consent

Clinical photography and video | Complete before images are taken

01 Patient details

Full name

Date of birth

Treating clinician

Date of imaging

02 Images and intended clinical use

☐ Photograph(s) ☐ Video (no audio) ☐ Other: _____

Body area / condition and reason for images

Who may receive the images for my care (name / service, or none)

03 What I understand

- The clinician has explained which images are needed, why they are being taken and how they may assist assessment, treatment or monitoring.
- Images may identify me, including through my face, tattoos or other features. Only the agreed area will be recorded, with my privacy and dignity respected.
- Images will form part of my confidential medical record and be stored securely. Access and any sharing will be limited to my care and the recipients listed above, or as required or permitted by law.
- This form does not authorise teaching, research, publication, advertising, website or social media use. Those uses require separate, specific consent.
- I can decline or ask for imaging to stop. The clinician will explain any effect on assessment and discuss alternatives. I may withdraw consent for future imaging or optional sharing by contacting the practice; images already in my record may need to be retained.
- I have had the opportunity to ask questions and request a copy of this form. I can ask reception about the practice privacy policy, access to my images or a privacy concern.

My decision (tick one)

☐ I consent to the clinical imaging described above. ☐ I do not consent.

Patient / authorised representative signature

Date

Representative name, relationship and authority (if applicable)

Clinician signature

Interpreter name / ID (if used)

Clinician: confirm capacity / authority, explain the scope and record any restrictions in the clinical notes.