ADAM BRAY
DERMATOLOGY

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Date: Patient name: ID:

## Patient consent for medical photography

**I confirm that:**

1. I have received adequate information about the purpose of these photographs
2. I have had an opportunity to ask questions about the use of these photographs and received satisfactory answers
3. I agree to digital photographs of me to be taken and stored securely to be used for the following purposes as indicated below

**Level 1**
a) For my medical records and doctor's use only for my medical care

**Patient signature:** **Print name:**
**Date:**

**Level 2**
a) For my medical records and doctor's use only for my medical care
b) AND for teaching health professionals

**Patient signature:** **Print name:**
**Date:**

**Level 3**
a) For my medical records and doctor's use only for my medical care
b) AND for teaching health professionals
c) AND for showing to other patients or accessible to the general public in published books/ journals or on websites (without any personal information attached)

**Patient signature:** **Print name:**
**Date:**

Email copy to patient: **Y N**

Dr Adam P.J.J. Bray MBChB MRCP (UK) Derm
Consultant Dermatologist (GMC: 6049496) Signature: