

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Hospital/clinic _____ Photographer _____

I give my consent for medical photographs (clinical images) to be taken of me or of my child (or person for whom I am legal guardian).

The DermNet New Zealand (*DermNet*) website provides information about skin diseases and their treatment to consumers and health professionals worldwide.

- I understand that copies of my photographs will be provided to *DermNet*.
- *DermNet* is allowed to use these photographs indefinitely unless I withdraw my consent.
- I have the right to withdraw consent at any time by writing to *DermNet*.
- Images displayed on *DermNet* will not include my name.
- I understand that this will not affect my treatment in any way.

DermNet does not ordinarily include photographs of full face or identifiable tattoos unless you have given express permission for this. However, complete anonymity cannot be guaranteed.

- I understand that on request, DermNet NZ may agree to supply a copy of the images to another person or organisation.
- DermNet NZ may charge a fee to do so to offset the time and effort required. I understand I will not receive any payment should this occur.

By signing this form I confirm that I consent for the images to be used for education, publication and research. For example:

- Use in lectures, school reports, research articles, scientific posters, textbooks
- Publication in professional journals or other print or electronic media including other websites and television programmes
- Other purposes that DermNet NZ decides appropriate.

Name of patient _____

Your name (if parent/caregiver) _____

Signature _____ Date _____



Contact us: info@dermnetnz.org
www.dermnetnz.org

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