R.O.A.D.S.

COMMUNITY CARE CLINIC

INFORMED CONSENT TO PHOTOGRAPH

Date: _____

I, _____, hereby give consent for ROADS Community Care
(Patient/Legal Guardian)
Clinic to photograph me (or person for whom I am legal guardian) for identification purposes, diagnosis and routine treatment.

I understand that these images and information will be used in an appropriate and respectful manner, and stored in a safe and regulated environment, with controlled access.

I understand that if at any point, I no longer give consent for photography that it is right to refuse.

- ☐ I consent for these photographs to be used in my medical record as part of management, before and after a procedure, comparing the progression of skin disease, therapeutic purposes.
- ☐ I decline consent for photography.

Name of patient:_____

Signature: _____

Name of patient guardian:_____

Signature:_____