# VIDEO CONSENT FORM

|  |  |
| --- | --- |
| The doctor named in the box opposite is making a video recording of their consultations. Intimate physical examinations will NOT be recorded and the camera will be switched off on request.The recording will be used for the purposes of the doctor’s learning, research and teaching; and the doctor is responsible for the security and confidentiality of the video recording.Today’s recording might be shared with other doctors who will give feedback to your doctor on their consultations. The recording will be erased as soon as possible but definitely not later than one year after the date of the recording.If, after you have left the surgery, you change your mind and wish the consultation to be destroyed, please contact the doctor or service within 10 days, either in writing or by phone or in person. | **Please complete in CAPITALS** |
| Date: |
| Doctor: |
| Patient: |
| Name of person/s accompanying patient to consultation: |

## TO BE COMPLETED BY THE PATIENT

I have read and understand the information leaflet (please tick appropriate box)

|  |  |
| --- | --- |
|  | I give my permission for my consultation to be video recorded |
|  | I do not give my permission for my consultation to be video recorded |

|  |  |
| --- | --- |
| To be signed **BEFORE** consultation | Following my consultation I am still willing for my consultation to be used for the above purposes |
| **Signatures of Patient, and Person(s) accompanying patient to consultation AGREEING to be videoed** | **Please initial below** |
|  |  |
|  |  |

Please state below if you wish to limit the use to which the video might be put, and whether you require the video to be erased within a specified period of time.

|  |
| --- |
|  |