Dermatology Advice and Guidance Consent Form

**Patient Details**

Name…………………………………………………………………………………………..

NHS number ………………………………………………………………………………..

**Section A** - To be completed by patient

I agree to have a digital photograph taken using a digital or smartphone camera ☐

I give permission for the photograph to be stored in my medical records **and** shared electronically with doctors at the hospital so that they can advise my GP on the diagnosis and treatment of my skin problem

If you give your permission for the photograph to be used in the education and training of other doctors please tick here. ☐

If you wish to withdraw consent for use for educational purposes please contact the Trust [please email [Lorna.Gregory@UHBristol.nhs.uk](mailto:Lorna.Gregory@UHBristol.nhs.uk) and [Patricia.Parsons@UHBristol.nhs.uk](mailto:Patricia.Parsons@UHBristol.nhs.uk)] and we will make our best endeavours to remove any images for educational purposes. However we may not be able to withdraw de identified images, or those that have been used in educational materials shared outside the Trust

Patient Signature. …………….……………………………………....…….. Date …………........

OR Legal Guardian Name……….…………………………Signature…………………………….........

**Section B** – to be completed by the doctor

Doctor’s name…………………………………………………………………………….

If using my own smartphone camera, I agree to managing this data securely in accordance with the Data Protection Act requirements. This includes using nhs.net, deactivating cloud photo sharing and deleting the images from my device afterwards. All data and images will be held confidentially and only used for clinical care. The patient has the right to object or withdraw consent at any time by advising me of this.

Doctor’s Signature…………………………………………………………Date…………………………