**PATIENT CONSENT FOR PHOTOGRAPHY/VIDEO RECORDING**

I give my permission for photographs and/or video to be taken during my consultation today.

[ ] I understand that these will be used for clinical and teaching purposes, and they will not be released to persons outside the GP Unit without my consent.

[ ] I provide consent for my photos/videos to be used for educational purposes outside of the GP Unit.

……………………………………. Patient Signature

……………………………………. Date

……………………………………. Witness Signature

……………………………………. Date