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## Template consent form for the use of photographs

Name of patient

Name of parent or guardian (if applicable)

Address

I have received an explanation of the reasons why [*name of practice / department / dentist*] wishes to take photographs of my face, mouth and teeth. The photographs might be used for:

- 🍏 Clinical purposes relating to my treatment and kept with my confidential dental records
- 🍏 For teaching purposes with dental students
- 🍏 For demonstrating clinical techniques at scientific lectures
- 🍏 In papers published in scientific journals.

I agree to the photographs being taken by [*dentist OR employee of the (name of establishment)*] and consent to their use for the purposes described above, and in accordance with current data protection legislation. When used for any purpose not directly related to my care, the photographs will be made anonymous by obliterating the eye area of the photographs so that I cannot be personally identified when they are used in lectures or publications.

If, for whatever reason, the photograph cannot be modified to protect my identity, [*dentist OR employee of the (name of establishment)*] will contact me to explain the reasons and seek my consent for use of the photographs. I understand that the photographs will not be used in these circumstances unless my consent is obtained.

Signed and dated by patient or guardian

Print name