HOSPITAL _____

PHOTOGRAPHY/MULTIMEDIA CONSENT FORM

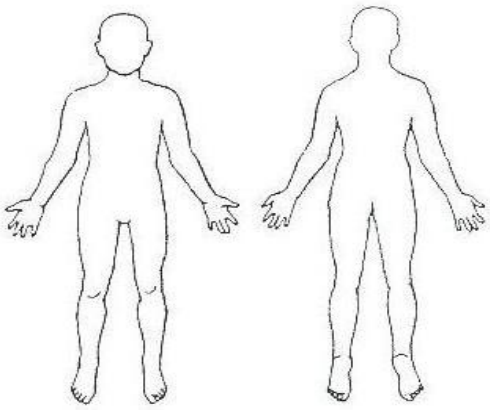
PER/PHOTO/2016

Name of patient : _

IC/ID No. : _

MRN : _

Indicated in the diagram below, is the area(s) which is/are to be photographed/recorded (if applicable):



Front Back

Part(s) of the body in words:

(1) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(2) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(3) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(4) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

(5) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I, *parent/guardian/spouse/relative of the above named, consent to the *photography/multimedia recording, as indicated above, of *myself/the said patient, to be used only for diagnostic, treatment, teaching, academic and research purposes. The record is not for commercial or personal publication. However, I agree and give my consent for this record to be used for health promotion or teaching. I have been explained and understand that *my/the patient's identity and modesty will be protected as far as possible.

Signature of *patient/person consenting: _ _ _ _ _ _ _ _ _ _

Name of person consenting : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Relationship : _ _ _ _ _ _ _ _ _ _ _ _ _ _

IC/ID No. of person consenting : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Translator (if any):

Signature : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name : _ _ _ _ _ _ _ _ _ _ _ _ _ _

IC/ID No. : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Language used : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Requesting person:

Signature : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Designation : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

IC/ID No. : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Witness:

Signature : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Designation : _ _ _ _ _ _ _ _ _ _ _ _ _ _

IC/ID No. : _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date : _ _ _ _ _ _ _ _ _ _ _ _ _ _

*Delete as appropriate