London Health Sciences Centre

CONSENT FOR PHOTOGRAPHY, VIDEO AND AUDIO RECORDING

ADDRESSOGRAPH

SECTION A: Consent for Photography / Recording

I, _____ ,
NAME OF PERSON GIVING CONSENT

consent to: ☐ Photography ☐ Video Recording ☐ Audio Recording

of me / my: _____
RELATIONSHIP AND NAME OF PERSON BEING PHOTOGRAPHED / RECORDED IF DIFFERENT FROM PERSON GIVING CONSENT

for the purpose of: ☐ Patient Care ☐ Education ☐ Quality Assurance ☐ Research
☐ Corporate Communications/Public Relations ☐ Other:_____

Provide Details: _____

_____

_____

_____

I understand that:

- Images / recordings will only be used for the purpose(s) described above.
- London Health Sciences Centre will ensure appropriate safeguards are in place to protect my personal health information from unauthorized access, use and disclosure, in accordance with applicable laws and information security standards.
- I may withdraw my consent or place restrictions on the collection, use and disclosure of images/recordings. If I choose to withdraw my consent or place restrictions, my care/treatment will not be affected in any way. I further understand that it may not be possible to withdraw consent for photography, video and/or sound recordings taken for some purposes (e.g. images requested for publication in a journal, information leaflet, or on the internet which may be seen, copied, or transmitted by members of the general public without authorization of LHSC).

I have had the purpose of the photography / recording explained to me and had any questions answered to my satisfaction.

READ ONLY - E-CONSENT IN CLEANUP REGISTRATION

Date: _____ _____
YYYY/MM/DD SIGNATURE OF PERSON GIVING CONSENT

SECTION B: Staff/Affiliate Statement of Informed Consent

I, _____ have explained the nature and
NAME OF LHSC STAFF / AFFILIATE OBTAINING INFORMED CONSENT

purpose of the photography / recording for which consent has been obtained. I have answered the questions of the patient / substitute decision maker to the best of my ability. To the best of my knowledge, the patient / substitute decision maker is giving his or her informed consent to the proposed photography / recording voluntarily.

Date: _____ _____
YYYY/MM/DD SIGNATURE OF LHSC STAFF/AFFILIATE OBTAINING INFORMED CONSENT

Completed form to be placed on patient chart, or retained by the responsible department, as applicable.