Obagi Medical
Photography Consent Form

PATIENT CONSENT

I, _____

Given Names Surname

Consent to medical images and/or video being made of me or my child/dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images and results of my investigative tests may be: (Please tick below to show consent)

	Yes	No
Placed in my medical record for future treatment	☐	☐
Electronically emailed to my treating Healthcare Professional	☐	☐
Used by Healthcare Professionals for education and training	☐	☐
Used in paper or electronic health publications or advertising	☐	☐
As above but with eyes blacked out	☐	☐

Date of first photo _____ Date of second photo _____

Products used _____

Treatment start date _____ Treatment finish date _____

By signing below, I confirm that I understand, acknowledge and agree to the content of this consent form.

Patient's signature:	Date:
Doctor's signature:	Date:
Department use only Comments: Name and signature of staff member:	Date: