

## Patient Consent Form for Video/Digital Recording for Training Purposes

|  |  |                                  |  |
|--|--|----------------------------------|--|
| <b>Patient's name:</b>   |  | <b>Place of Video Recording:</b> |  |
| <b>Name of person(s) accompanying patient to the consultation:</b> |  | <b>Date:</b>                     |  |

We are hoping to make video/digital recordings of some of the consultations between patients and Dr ..... whom you are seeing today. The videos are used by doctors training to be a GP to review their consultations with their trainers. The video/digital recording is ONLY of you and the doctor talking together. Intimate examinations will not be recorded and the camera will be switched off on request.

All video/digital recordings are carried out according to guidelines issued by the General Medical Council, and will be stored securely in line with the practice guidelines. They will be deleted within one year of the recording taking place.

You do not have to agree to your consultation with the doctor being recorded. If you want the camera turned off, please tell Reception - this is not a problem, and will not affect your consultation in any way. But if you do not mind your consultation being recorded, please sign below. Thank you very much for your help.

**TO BE COMPLETED BY PATIENT**

I have read and understood the above information and give my permission for my consultation to be video recorded.

**Signature of patient BEFORE CONSULTATION:**

..... Date .....

**Signature of person accompanying patient to the consultation:**

..... Date .....

After seeing the doctor I am still willing/I no longer wish my consultation to be used for the above purposes.

**Signature of patient AFTER CONSULTATION:**

..... Date .....

**Signature of person accompanying patient to the consultation:**

..... Date .....