(Identification Label) M.R.N
Name
Address
Date of Birth / / A.M.O

AUDIO-VISUAL CONSENT FORM

I _____

of _____

hereby consent to *myself/my _____ _____
(Relationship) (Name)

☐ **VIDEOTAPED** ☐ **AUDIO-RECORDED** ☐ **PHOTOGRAPHED**

During *my/his/her treatment at Liverpool service:

I agree to the recording or photographs being taken and used for
(tick whichever is applicable):

☐ Clinical Presentation

☐ Teaching

☐ Public Relations

As explained to me by _____

STAFF SIGNATURE_____ DESIGNATION _____

I understand when this recording or photographs are used for purposes other

than the treatment of *myself/my _____ that patient
(Relationship)

confidentiality will be respected.

SIGNATURED:_____ **DATE:** _____

(* Delete as required)

AUDIO VISUAL CONSENT FORM

LIVERPOOL HEALTH SERVICE