**Sample consent form**

Patient/parental agreement to use audio or visual records

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| --- | --- |
| **Patient name:** (*or attach identifier sticker)* |  |
| **Date of Birth:**       |  |
| **Hospital number:**             |  |

**Type of recording made:**

* Videofluoroscopy recording
* FEES recording
* Video recording of assessment/treatment session
* Audio recording of assessment/treatment session
* Photographs

**I consent to the use of the recordings for the following purposes**:

* For educational purposes within   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*Trust)*

* For teaching purposes external to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(*Trust)*

*(E.g. national/international teaching/training)\**

* For publication use   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(e.g. journal articles, intranet, internet, information leaflets and other published media)*

*Any recordings used for assessment/treatment planning are deemed part of the patient’s medical records and will be stored in accordance with Trust guidelines and treated at all times as confidential. All other recordings will be available for use as indicated above for a period of ……………………After such time the recording will be destroyed or consent for continued use will be obtained.*

*This consent can be withdrawn at any time by the signatory*

*\*By signing this consent it is understood that … Trust may not be able to control future use of the material once it has been placed in the public domain*.

Signature: ……………………………………..                              Date: ………………………..

Print Name: ……………………………………

Signature of clinician: ……………………………..                    Date: …………………………

Print name: ………………………………………..

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| **Consent has been withdrawn by signatory** Date: ………………                   Signed: ……………… **Recordings destroyed**                                   Date: ……………… Signed: ………………  |

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