CONSENT FORM

1. Preferred method of communication. Please tick as many as you want:

☐ Phone
☐ Voicemail
☐ Email
☐ Post
☐ Any special instructions: ____

2. Preferred method of sending confidential data i.e. clinical letters, results. Please tick as many as you want:

☐ Encrypted email
☐ Unencrypted email *
☐ Post
☐ Any special instructions: ____

***IMPORTANT:** I understand the risks of unencrypted emails.

3. Sending copies of your clinic letters/results to your preferred clinician/s, General Practitioner/s or nominated third party person e.g. interpreter or relatives. Please provide name and address or email address where to send:

GP's Name: ____
Name of Surgery & Address: ____
____
Email: ____

Consultant's Name: ____
Name of Surgery & Address: ____
____
Email: ____

Others: ____
____

4. Photos may be taken only when it is necessary to document your response to treatment e.g. before and after pictures, which will be stored securely for your medical records only.

☐ Yes

☐ No

This is to confirm that I have read the privacy notice & understand fully what I have consented. Also, that I have checked my registration form and provided my most up-to-date details.

Patient's Signature: ____

Printed Name: ____ **Date** ____________________