

[University Name]
[Faculty Name]

Intended Purpose:

(Block Capitals)
 Student Name
 Address:
 Postcode:
 Telephone:
 Email:
 Date:

Member of Staff:

I hereby confirm that I give consent for the photographs and/or video images and/or sound recordings (the 'material') to be made of me, as described below.

I consent to the material being shown to medical/dental/veterinary staff and students, used in publications, journals and textbooks and used in any other form or medium including all forms of electronic publication or distribution anywhere in the world including the Internet. As a result, I understand that the general public will see and may purchase the material. All or part of the material may be used in conjunction with other photographs, drawings, videotape images, sound recordings or other forms of illustration. I realise that if publicly available material is used by a third party then the University of # is not at fault and any grievance should be directed at the third party.

I can view the material by arrangement with the University of # Clinical Skills facility. However, once released, I realise that recovery of the material may not be possible. I understand that no fee is payable to me by the University of # or any other person in respect of the material either now or in the future.

I confirm that the purpose for which the material would be used has been explained to me in terms that I have understood.

Refusal to consent will in no way affect my studies or medical care. All data will be held in accordance with the Data Protection Act, 1998 and not disclosed.
 Please tick the box only if you agree.

<input type="checkbox"/>	I AGREE with the above statement	Signature:
	Date:	Print Name:

Clinical Skills
Faculty of #
University of #
 Email: #
 WWW: #
 Phone: #
 FAX: #