University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

PhotoGraphics

Clinical Photography Request/Consent

UHN PhotoGraphics can photograph in clinics, inpatient units or at our studio, PMH 3B-405. Open 0900-1700 or by arrangement. Complete the requisition and call 16-4475 to make arrangements for clinic or inpatient unit photos. No appointment is necessary for studio photos but patients must have a completed requisition, including consent, with them. Studio photography is superior as we have control of lighting and background. We can accommodate full body to 2x magnification close ups.

N.B. If dressings are to be removed/changed assistance should be available.

Clinical Photography Request:

Date:	Diagnosis:	Diagram:

Photos to demonstrate: _____

Requested by: _____ **PMH** Program: DRO ☐ DSO ☐ DMO ☐

Phone number where you can be reached **now:** _____ **TGH** Program: _____

TWH Program: _____

To be completed by requesting physician/health practitioner or UHN PhotoGraphics staff.

I confirm I have explained that images or recordings containing the patient's personal health information may be used for external teaching and research purposes and answered any questions.

Signature: _____ Date: _____

Please e-mail me copies: ☐

_____

E-mail Address

This request has no validity unless photography is performed by bona fide PhotoGraphics staff.

Consent for Use of Photography, Video or Audio Recording for Teaching or Research Purposes

I/We hereby authorize University Health Network (Toronto General, Toronto Western and Princess Margaret Hospitals) and its staff, employees and agents to take, exhibit, publish, broadcast and otherwise distribute images and/or recordings of the above named patient before, during and after treatment, upon the understanding that the University Health Network and its staff, employees and agents use said materials only for medical, scientific or educational purposes. I understand that I may withdraw this consent at any time upon written notice to the University Health Network. This will not affect my treatment and/or affiliation with the University Health Network in any way.

- I hereby waive any claim for payment arising from any use made of my image, recording or information.
- I hereby waive all claims against the University Health Network in connection with any use or disclosure made of my image, recording or other personal health information where I have consented to such use and disclosure.

This document has been read over and explained to me and I clearly understand its meaning.

_____

Name of Patient/Substitute Decision Maker (please print)

Please check & initial if you **do not** consent to identifiable photos: ☐ _____

_____ _____

Signature

If Substitute decision maker, please state relationship

Dated this ____ day of _____ **20**___

If signed other than by patient, relationship should be inserted beside signature of the person signing and proof of authority should be produced. If patient is under 18, parent or guardian must also sign beside signature of patient.

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