1819

Queensland Government

Metro South Health

Clinical Film/Photo Consent

Facility: .....

Activity/location/context/purpose: (insert description) **Allied Health Careers Forum 2017**

photography for promotional purposes only Date: **3 May 2017**

I, (insert name).....

of (insert address).....

For Parents/legal guardians of children (if applicable)

1. **declare** that I am the parent/legal guardian of the following child or children (collectively "the Children")

....

2. **agree** to the State of Queensland, its employees, officers, agents and contractors ("the State")
   a) Making images or recordings, whether sound, digital or otherwise, of me and the Children to assist with clinical diagnosis, treatment, ongoing care and clinical teaching ("Images and Recordings")
   b) Using, publishing or reproducing the Images and Recordings in any form (in whole or in part) and by any medium, including but not limited to clinical records (paper and electronic), clinical research publications ("Media related to your condition")
   c) Retaining or storing the Images and Recordings (including those incorporated into Media related to your condition), in hard copy or digitally, including but not limited to, deposit or the Images and Recordings into a clinical record;
   d) An explanation of why the image/s is required, how the image will be taken and any risk, discomfort or special preparation required for the image to be taken
3. **agree** that rights granted to the State under clause 2 of this Clinical Film/Photo Consent Form are perpetual and that I will not receive any payment, royalty or other consideration (whether monetary or otherwise) from the State in connection with the making, use or storage of the Images and Recordings;
4. **agree** to the State collecting, storing, handling, accessing, managing, transferring, using and disclosing personal information about me and the Children, including but not limited to our name, details and image, in connection with the Images and Recordings or the Media related to your condition;
5. **acknowledge an agree** that any Media related to your condition which refer to me and the Children, expressly or by implication, are, at the date of publication, made in good faith and are not intended to defame or offend me or the Children or bring me or the Children into disrepute and, to the best of the State's knowledge, are true and correct;
6. **agree** that the State is the owner of the copyright in the Images and Recordings and the physical Images and Recordings; and
7. **acknowledge** that a representative of the State has explained the contents of this Clinical Film/Photo Consent Form to me and I am signing this Clinical Film/Photo Consent Form of my own free will, on the full understanding and comprehension of the terms of this Clinical Film/Photo Consent Form.

Images are stored: ☐ Patient Medical Record
☒ Electronically (insert file path) **Y:/MCOMMS**

Signed by:	**Witnessed by:**
.....	.....
Print name	Print name
....	....
Signature Date	Signature Date

Contact Officer: **Julie-Anne Ross** Department/Agency: **Metro South Health**

Phone: **3176 5715** Photographer/Credit: **N/A**

Privacy Notice

The Department/Agency is collecting the information on this Clinical Film/Photo Consent Form in order to use Images and Recordings of your or the Children in clinical diagnosis, treatment and as otherwise stated above. This information will only be accessed by authorised personnel of the clinical record for the delivery of your health care. Your information will not be given to any person or agency unless you have given us your consent or we required or permitted by law.

DO NOT WRITE IN THIS BINDING MARGIN

V3.0 11/2012

Clinical Film / Photo Consent