PHOTOGRAPHY/AUDIOVISUAL RECORDING CONSENT FORM

Information regarding the reasons for, and the uses of, the proposed photograph/audiovisual recording shall be provided to you prior to the completion of this form. You may seek further information before consenting.

I, ____________________________________________________________

(Full name of person or Legal Guardian/Parent for person under age of 18, or person who is unable to give consent due to physical disability)

Hereby consent to the WA Centre for Rural Health

Participating in one or more of the following recordings during:

(Please describe reason for recording i.e. wound management, counselling, workshop name etc)

☐ Photography (camera taking a photograph)

☐ Audiovisual Recording (camera recording visual and sound)

Mark appropriate boxes to GIVE consent for the recording to be used for that purpose
Leave boxes blank if you DO NOT consent to the recording being used for that purpose

I consent to the recording being used for:

☐ Education and Training 
This may involve the use of the images/recordings for education of Health professionals. Audiovisual recordings will not be used with identifying information such as name.

☐ Promotion/ Marketing
This may involve the use of images/recordings for WACRH marketing (flyers, website) and or use in reports, conference papers used as a regional, state, nationals or international level.

☐ Research
This may involve the photographs/audiovisual recordings being used in publications and presentations. Audiovisual recordings will not be used with identifying information such as name.

Period of Consent: Images will be reviewed after 12 months for deletion

Person giving consent: _____________________________________________

Signature: ___________________________ Date: / /

Staff member: _______________________ Name/Designation: ______________________ Date: / /

(Signature) (Please Print)