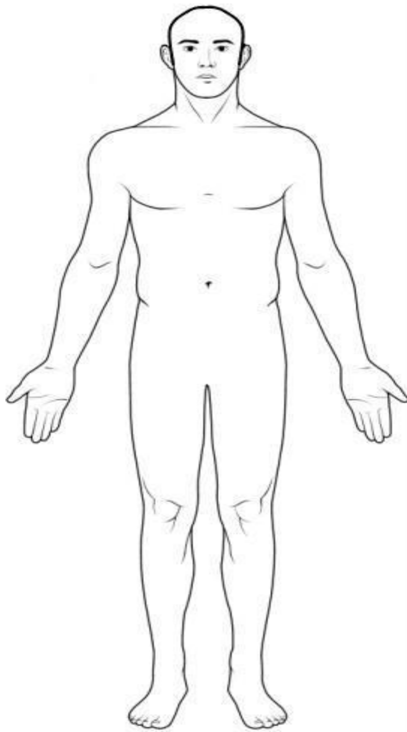
	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Kod Dokumen: HSAAS/MEDIC/BR25**
	PHOTOGRAPHY CONSENT FORM

Diagnosis: ____

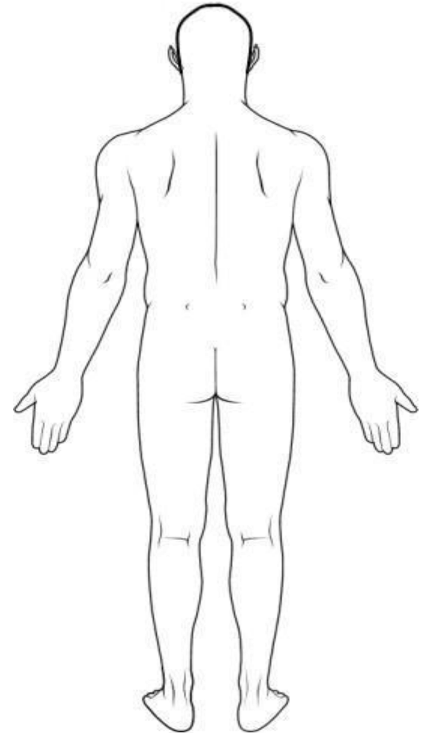
Keywords: ____

Date of Photo: ____________ Clinical Photo No.: ______________ HPE Photo No.: ______________

Biopsy Date: _______________________________ Biopsy No.: ____________________________



1. Please indicate on the diagram the area(s) to be photographed.
2. Specify any lesion(s) which require a close-up view



I,____(IC No.:__________________________) the father/mother/guardian of ____, give my consent for photographs to be taken, as indicated above, of the said patient and for photographs to be used by the Department for diagnostic / record / teaching / academic / publication purposes only. I understand that the Department authorities will, to the best of their ability, protect my identity in the event that the photographs are reproduced in the teaching sessions, academic discussions/meeting and medical/scientific journals. Signature of Patient/Person giving consent: ______________________

Date: ___________________

REQUESTING MEDICAL OFFICER	**WITNESS**
Name :_____________________________	Name :_____________________________
Signature: _____________________________	Signature:_____________________________