TWEEDDALE MEDICAL PRACTICE
EOLAS SAIDHEANS LE TRUAS

FortWilliam **HealthCentre**
Ionad Slainte A'Ghearasdain

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CONSULTATION REVIEW CONSENT FORM

<<<Patient Label Here>>>	**Date**
Names of persons accompanying patient to consultation	
Name of consulting doctor	

Dr …….. is recording his/her consultations today. Intimate physical examinations will not be recorded and the camera will be switched off on request. The recording will be used for the purposes of assessment of the doctor, research, learning and teaching and may be required to be copied securely for these purposes.

Dr …….. is responsible for the security and confidentiality of the recording – which will remain encrypted.

Today's recording will only be seen by authorised doctors within the practice and possibly other authorized doctors, outwith the practice, who are responsible for assessing your doctor on his/her consultations. The recording will be erased as soon as possible but definitely not later than one year after the date of the recording.

If you reconsider once you have left the surgery and wish Dr……..…..to destroy the recording, please contact him/her **in writing, by telephone or in person as soon as possible**.

TO BE COMPLETED BY THE PATIENT

I have read and understand the information leaflet (please tick appropriate box)

- **I give my permission for my consultation to be recorded**
- **I do not give my permission for my consultation to be recorded**

State here if you wish to limit the use to which the recording might be put and whether you require the tape to be erased within a specified period of time……...

Signature of patient **BEFORE CONSULTATION** ……..…… Date:……

Signature of person accompanying patient to consultation ……

FOLLOWING MY CONSULTATION I am still willing/I no longer wish my consultation to be used for the above purposes.

Signature of patient **AFTER CONSULTATION** …… Date: ……..

Signature of person accompanying patient to consultation ……