Confidentiality and Consent
A Guide to Good Practice

IMI National Guidelines
The IMI National Guidelines have been prepared as baseline guides on specific aspects of medical illustration activity and provide auditable standards for the future.

The Guidelines can either be implemented in full, or may be amended according to individual requirements.

Copies are available on the IMI website (www.imi.org.uk).
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Objective

To provide good practice guidance for medical illustration and other healthcare professionals making, using and storing visual recordings of patients in maintaining patients’ rights to confidentiality, obtaining appropriate consent and complying with relevant legislation and professional practice, in the best interests of both parties.

The term visual recording in this guidance has been used to describe both photographic images and video recordings of patients, taken on traditional or mobile imaging devices.

Introduction

Visual recordings used for treatment planning, diagnosis, and recording and monitoring the progress of the patient’s condition, form an essential part of a patient’s healthcare record. They are perhaps unique amongst records in that patients can be easily identified from such recordings, as they represent a direct likeness of the subject.

Medical illustrators and other healthcare professionals must understand the complexities of capture, security, storage and retrieval of visual recordings and the implications of relevant legislation such as the Data Protection Act (DPA) 2018. They have a duty of care to ensure appropriate confidentiality and consent policies and protocols are in place. The consequences of visual recordings being inadvertently used beyond the purposes for which the patient has consented, or deliberately misused, can be far reaching and costly.
## Key Legislation

| **The Data Protection Act 2018** | The Data Protection Act 2018 is a complete data protection system; as well as governing general data covered by the European Union's General Data Protection Regulation (GDPR), it also covers all other general data, law enforcement data and national security data. |
| **The Caldicott Report (1997)** | The Caldicott Report (1997) and subsequent Caldicott or National Data Guardian reviews recommend that a series of principles be applied when considering whether confidential patient-identifiable information should be shared. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian (a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly). |
| **The Common Law Duty of Confidentiality** | The Common Law Duty of Confidentiality is a form of law developed through decisions of the court rather than by statute or regulation. It infers that information given in circumstances where it is expected that a duty of confidence applies cannot normally be disclosed without the information provider's consent. |
| **The Confidentiality: NHS Code of Practice (2003)** | The Confidentiality: NHS Code of Practice (2003) outlines the four requirements that must be met in order to provide patients with a confidential service.  
  - Protect: look after a patient’s information.  
  - Inform: ensure patients know how their information is used.  
  - Choice: allow patients to decide where and how their information can be shared.  
  - Improve: look for better ways to protect, inform and provide choice to patients. |
| **The Human Rights Act (1998)** | The Human Rights Act (1998), Article 8, refers to an individual's right to respect for their private and family life, for their home and for their correspondence. This means that public authorities should take care that their actions do not interfere with these aspects of an individual's life. |

* It should be noted that case law evolves over time and further legal developments may occur after this guidance has been issued. Medical illustrators and other healthcare professionals must keep themselves informed of legal developments which may have a bearing on their practice.
Section 1. Patient Confidentiality

All those who work in the NHS are bound by a legal duty of confidence to protect personal information they may come into contact with during the course of their work. This is not just a requirement of their contractual responsibilities (where staff are required to participate in induction and training on confidentiality and data protection issues), but also a requirement within the common law duty of confidence and data protection legislation (GDPR and the DPA 2018).

NHS employees are bound by the relevant national code of practice in relation to patient confidentiality, which state that any breach of confidence, inappropriate use of health records or abuse of computer systems can lead to disciplinary measures, bring into question professional registration and possibly result in legal proceedings.¹,²,³,⁴

Healthcare professionals also work under their own code of conduct specific to their professional and/or regulatory body, which include legal, moral and ethical codes in relation to patient confidentiality. Such codes provide assurances to patients and the public, and help develop trusting relationships with healthcare workers:

Patients entrust and allow us to gather, sensitive information relating to their health and other matters as part of their seeking treatment. They do so in confidence and they have the legitimate expectation that staff will respect their privacy and act appropriately.⁵

Professional members of the Institute are bound to practice within the terms of the IMI Code of Professional Conduct for Professional Members,⁶ which outline the standards required to maintain professional practice. The Academy of Healthcare Science document, Good Scientific Practice, also sets out the principles, values and the standards of behaviour and practice for the healthcare science workforce, including those on the Accredited Register for Medical Illustrators.⁷

A breach of confidentiality involving a visual recording has the potential to cause great distress to the patient and could lead to grave consequences for both the employer and the healthcare worker(s) concerned.

Example

A patient was admitted to the ward following a serious work injury which resulted in the loss of three fingers of the left hand. Photography was requested and on returning to the department, the clinical photographer proceeded to discuss the case with another visiting healthcare professional. Due to the interesting nature of the case, the healthcare professional asked to see the photographs, which the photographer duly displayed on the screen.

This is a breach of confidentiality as the photographer disclosed clinical and personal data to a healthcare professional not involved in the patient’s direct clinical care.
Understanding data processing and GDPR

**Data processing** means obtaining, recording or holding (personal) data or carrying out any operation or set of operations on the data, including a) organisation, adaptation or alteration; b) retrieval, consultation or use; c) disclosure by transmission, dissemination or otherwise making available; or d) erasure or destruction of the data. Data processing is therefore integral to all visual recordings in the healthcare environment, whether for direct care (treatment) or for secondary use (teaching, publication and research).

Within GDPR legislation, there must be a valid lawful basis to process personal data (under Article 6 of the Data Protection Act 2018). In healthcare, personal data is further classified as **special category data** (data concerning health, racial or ethnic origin, or sexual orientation information) and therefore needs more protection. To process special category data there must be both a lawful basis and a separate condition (under Article 9). For our purposes, the most relevant bases and conditions for visual recordings are as follows:

**For direct clinical care (consent to treatment)**
Article 6(1):
- a. processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller,
- and Article 9(2):
- b. processing is necessary for the purposes of carrying out the obligations and exercising the specific rights of the controller or of the data subject in the field of...social protection law... (in the case of safeguarding children and vulnerable adults) or,
- h. processing is necessary for the purposes of...medical diagnosis... and the provision of health or social care or treatment.

**For secondary use (teaching and publication)**
Article 6(1):
- a. the data subject has given consent to the processing of his or her personal data for one or more specific purposes (explicit consent),
- and Article 9(2):
- a. the data subject has given explicit consent to the processing of those personal data for one or more specified purposes.

**For secondary use (research)**
It is the responsibility of the research lead to identify the lawful basis and condition for data processing. Examples could be:
- Article 6(1):
- a. the data subject has given consent to the processing of his or her personal data for one or more specific purposes (explicit consent),
- e. processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller,
- f. processing is necessary for the purposes of the legitimate interests pursued by the controller,
- and Article 9(2):
- j. processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.

**Other lawful bases for data processing**
There may be other circumstances in which an alternative lawful bases for data processing would be more suitable e.g. a contract or a legal obligation. Always take advice from your Data Protection Officer and/or Caldicott Guardian to be sure that you are processing data legally.
Section 2. Consent

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.\(^9\)

For the purposes of this document:

Section 2.1 discusses consent to treatment and the ethical obligation to gain informed consent from a patient before they receive any type of medical treatment, test or examination.

Section 2.2 discusses consent for secondary use and the ethical and legal obligation to gain informed consent from a patient to use data beyond those purposes for which it was originally collected.

2.1 Consent to treatment (direct clinical care)

Consent to treatment means a patient must give permission before they receive any type of medical treatment, test or examination. As a visual recording is generally regarded as a test or procedure, a patient must therefore consent to having a visual recording taken. To preserve their dignity and privacy, they should be given information on why the recording is being made, and how it will be used.\(^{10,11}\)
2.1.1 Who should seek consent to treatment?

Patients should give their consent to the healthcare professional directly responsible for providing the treatment (test). It is therefore good practice for the medical illustrator or healthcare professional making the visual recording to ensure that the patient consents to the treatment (test).\textsuperscript{12}

2.1.2 Who should provide consent to treatment?

<table>
<thead>
<tr>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults should provide consent to treatment on their own behalf. No-one, including parents, relatives and health and social care professionals, can give or withhold consent on behalf of another adult unless special legal provision for particular purposes has been made for this. This could include a Power of Attorney or a Welfare Guardian, in accordance with the relevant legislation. See Section 2.1.6.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young people over the age of 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people over the age of 16 are presumed in UK law, to have the capacity to consent to treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children or young people under 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children or young people under 16 can provide their own consent to treatment if, in the opinion of a qualified medical practitioner, they have the capacity and understanding to appreciate the implications of their decisions (referred to as Gillick competence in England and Wales). They should, however, be encouraged to involve their parents/carers (person with parental responsibility) in decision-making. Where a child or young person is not able to understand the nature, purpose and possible consequences of the visual recording, consent must be obtained from the person with parental responsibility.</td>
</tr>
</tbody>
</table>
2.1.3 How should consent to treatment be documented?

Consent to make a visual recording should be properly discussed, understood and agreed by the patient, and a record of any key elements of discussion recorded in the healthcare record.\textsuperscript{13} Validity of consent does not depend on the form in which it is given, therefore can be in writing, verbally or non-verbally (as long as the patient understands the treatment about to take place).\textsuperscript{14}

Options for recording a patient’s consent to a visual recording for direct care purposes include:

\begin{itemize}
  \item a declaration by the medical illustrator or healthcare professional making the visual recording. This can include an initials box on a request form to indicate that consent was properly discussed, with space for any key elements of discussion (\textit{Figure 1}).
  \item a patient signature on a traditional visual recording consent form (\textit{Figure 2}). Note, this is not a legal requirement, but can serve as evidence of consent.
\end{itemize}

The method of documentation of consent to treatment for a visual recording for direct care is a local Trust or Health Board decision. Regardless of method, it is important that the requirements that constitute valid consent are met, i.e. the person has the capacity to make the decision, sufficient information has been provided to ensure that consent was informed, and that consent has been freely given.

\begin{figure}
\centering
\includegraphics[width=\textwidth]{clinical_photography}
\caption{Sample of a declaration on a visual recording request form}
\end{figure}
Confidentiality and Consent

2.1.4 Implied consent

Where visual recordings form an integral part of a treatment or test, consent can be implied in the consent for that treatment or test, and does not need to be obtained separately. When seeking consent to a treatment or test that involves a visual recording, the patient should be advised of the recording, as although consent is implied, it is in the best interests of the patient to be open and transparent about any tests that have happened during their care pathway.

Examples include:

**Internal organs and specimens**
Consent to make visual recordings of internal organs or specimens is implicit in the consent given to the treatment.

**Specialist ophthalmic imaging**
Consent for ophthalmic imaging, such as retinal photography, fluorescein and ICG angiography, OCT and slit lamp photography is implicit in the consent given to the treatment.

(Refer to Section 2.1.6C if the patient is under anaesthesia at the time the visual recording is made).
2.1.5 Patient refusal of treatment

If a patient has capacity to make decisions independently, they have the right to refuse a treatment or test, and the decision must be respected. If a patient refuses the request for a visual recording, the healthcare professional that made the referral should be informed. If you have good reason to believe that a patient lacks capacity to make this decision, see Section 2.1.6.

2.1.6 Special circumstances (consent to treatment)

A. Patient capacity

According to UK mental health and mental capacity legislation, adults are presumed to have the ability to make decisions about whether to agree or refuse any aspect of their care or treatment independently; this is known as ‘an assumption of capacity’. A person can only be regarded as lacking capacity once all practicable support has been provided to that person to help them with making the decision. Assumptions of capacity must never be based upon a patient’s age, disability, appearance, medical condition, beliefs, ability to communicate or any other characteristic. Capacity to consent can be transient and therefore must always be considered according to the specific time, situation and decision. It may be acceptable to delay a recording until the patient is able to provide valid informed consent.

If a healthcare professional believes a patient lacks capacity to understand the consequences of consenting, and so cannot give informed consent to treatment, a third party with the legal right to make decisions on their behalf (e.g. under a Power of Attorney) can give consent.

Where this is not possible, then an assessment of the patient’s capacity should be made. In England and Wales this is known as a best interests assessment, in Scotland, the patient is assessed under the Adults with Incapacity Act, and in Northern Ireland, it is governed by the common law.

Healthcare professionals must always check that an assessment has been completed before undertaking visual recordings of patients lacking capacity to consent, and any action must be clearly documented in the patient’s healthcare record.

B. Vulnerable patients

Vulnerable patients, with the capacity to consent, must provide consent to treatment on their own behalf. They also have the right to refuse treatment, but must be made fully aware of the risk of refusing treatment, particularly if there is a significant or immediate risk to life. A record of their decision should be documented, along with the reason for their refusal of treatment if necessary. It is important to recognise that although an individual with capacity has the right to refuse care for themselves, such refusal may raise safeguarding concerns with respect to others, and therefore it is important to report any refusals back to the consultant caring for the patient. Refer to Section 2.1.6A if the vulnerable patient lacks capacity.
C. Patients under anaesthesia
In the case of the anaesthetized or unconscious patient, recordings may be taken provided the patient is informed of the recording and consent is obtained retrospectively. Consent to recordings may have already been discussed by a healthcare worker with the patient as part of the theatre attendance checklist, however it is professional and courteous to check that the patient is aware that a recording was actually made. This discussion should take place as soon as it is practically possible to do so, however, if it is impracticable (for example, if the patient is in a critical condition) then this should be documented and the recording should be placed into the patient’s record (for use in the best interests of their direct healthcare only).

D. Safeguarding children
In cases where injuries of a child are suspected to be non-accidental in origin e.g. suspected child abuse, consent to treatment must still be sought from the patient, the patient’s representative (person with the Lasting Power of Attorney for health and welfare), or the person with parental responsibility. If the person with parental responsibility is unavailable to give consent, then the decision to proceed will depend upon the circumstances of the clinical assessment, such as who has attended with the child and the perceived risk to the child. All efforts must be made to obtain consent before making any recordings of a child; recordings taken without consent may be ruled inadmissible during criminal proceedings in court.

If the child or person with parental responsibility refuses to consent to photographs being taken, this should be documented in the healthcare records and the clinician should make detailed notes accompanied by careful line drawings to illustrate the findings.

If consent is refused and yet it is considered to be in the child's best interest to have photographs taken, the medical practitioner should refer to legal authorities to obtain consent by court order.

For more information see the IMI National Guideline, Photography of Non-accidental Injuries.17

E. Pregnancy loss and neo-natal deaths
In the case of visual recordings of pregnancy loss (miscarriages and stillbirths) and neonatal deaths, the normal consent procedure for children should be followed.

For photographs taken as part of the bereavement process, parents should be asked by the responsible clinician or midwife as to whether they would like to have photographs taken. Consent should be recorded in the patient’s healthcare record. The matter should obviously be handled with extreme sensitivity; for more information see IMI National Guideline, Bereavement Photography (Neonates, Stillbirths and Children).18

F. Deceased patients
Visual recordings can be requested after a patient dies, often as part of a post-mortem examination. If the photographs have been requested for inclusion in the patient’s
healthcare record, in the best interests of the patient, then consent is not required from the patient’s representatives.

If a visual recording has been made of a patient, and they subsequently die before consent has been obtained, then the visual recording should be kept in the patient’s healthcare record as it forms an essential record of their care at that time. It is imperative that all decisions and actions are clearly documented in the patient’s healthcare record; ethical responsibility in terms of a patient’s confidentiality extends beyond their death.

2.2 Consent for secondary use (teaching and publication)

Secondary use of data is defined as any use of data (e.g. for research and publication) beyond those purposes for which it was originally collected (e.g. direct care). As the most appropriate lawful basis and condition for secondary use of special category data (visual recordings) is primarily consent, the GDPR has strict and high standards for obtaining that (explicit) consent. The regulations define consent as ‘any freely given, specific, informed and unambiguous indication of the data subject’s wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her’.19

Visual recordings of historical interest (archives), where consent has not been obtained or cannot be proven, can be used for secondary purposes, but only if an existing or newly consented recording (which would equally meet the purpose of the archive recording) is not possible.

2.2.1 Who should seek consent for secondary use?

Consent to secondary use and data processing (teaching and publication) is treated separately from consent to treatment, and is normally taken by the person responsible for the further use of the visual recording, or by a representative who is able to fully discuss the details of the secondary use and data processing.

To meet GDPR standards, and for the consent to be valid, the following information must be made available to the patient:

<table>
<thead>
<tr>
<th>The data controller</th>
<th>Information and consent forms should include the name of the organisation, including any third party controllers who will also rely on the consent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of the visual recording</td>
<td>Why the data is needed – provide details on why the visual recording has been requested, covering all purposes for which consent is sought, with granular options available to consent separately to each specific purpose</td>
</tr>
</tbody>
</table>
How the visual recording will be processed

What will be done with the data – specify where and how the visual recordings will be stored and used, providing granular consent options for each separate type of processing.

How consent can be withdrawn at any time

The option to withdraw consent, and how to do it, must be clear.

This information must be explained to patients in a way they can clearly and easily understand. The request for consent needs to be prominent, concise, separate from other terms and conditions, and in plain language; if the request for consent is vague, sweeping or difficult to understand, then it will be invalid.

2.2.2 How should consent for secondary use be recorded?

Consent should be given by a clear affirmative act, meaning the patient must take deliberate and specific action to opt in or agree to the processing. Examples include signing a consent statement, oral confirmation, or a binary choice presented with equal prominence. As GDPR Article 7(1) requires that you are able to demonstrate that a patient has consented, written consent using a standard visual recording consent form is recommended (Figure 3). You can obtain explicit consent orally, as long as a record of the script is held in the patient record.

**Clinical photography for secondary use**

This section should ONLY be completed if recordings are requested for secondary use e.g. teaching or publication.

About the visual recording:
Date of recording: ______________ Description: ___________________________

About the secondary use:
Consent to use the visual recording detailed above is requested for:

☐ Clinical research
☐ Presentation for educational use to healthcare staff and students
☐ Presentation to the general public
☐ Exhibition materials (e.g. clinical poster)
☐ Patient education (e.g. to show patients undergoing the same treatment)
☐ Publication in __________________________ (title must be provided)
☐ Other (details of intended use) ______________

Requestor’s name: _______________________
I have explained the nature and purpose of the secondary use to the patient.
Signature: ____________________________ Date: ______________

Your personal data will only be used for the purpose(s) detailed.

If at any time you do not want your personal data to be used for these purposes and wish to withdraw your consent, please contact the Clinical Photography department.

Patient’s name: _______________________

I understand the secondary use detailed on the form and give consent.

Signature: ____________________________

Date: ____________________________

**Figure 3. Sample consent section of a visual recording request form for secondary use.**
2.2.3 Patient refusal of consent for secondary purposes

Patients must be able to, and feel comfortable with refusing consent, without adverse implications to their healthcare. You should ensure that a patient does not feel any pressure to consent and allay any concerns over the consequences of refusing consent.

2.2.4 Patient withdrawal of consent for secondary purposes

If a patient withdraws consent, you need to stop processing based on consent at the earliest opportunity; this does not affect the lawfulness of your processing up to that point. It is recognised that any retrospective withdrawal of consent is not reliable, as information may already be in the public domain.

Example

A patient presenting with a rare condition gave written consent for teaching and for publication in January 2018. The images were shared with the consultant for a lecture he presented in February 2019. The patient contacted the medical illustration unit to withdraw consent for both teaching and publication in March 2019. The withdrawal of consent for teaching and publication was recorded in the patient healthcare record, meaning the images will not be released for any future use.

The images used in the presentation before the withdrawal of consent were processed lawfully under the original consent, but the consultant should be advised to delete the copy images and ensure no further use for teaching.

2.2.5 Third party consent for secondary use

Although the GDPR does not prevent a third party acting on behalf of a patient to indicate their consent, you need to be able to demonstrate that the third party has the authority to do so. In practice, it is likely to be difficult in most cases to verify that a third party has the authority to provide consent. You also still need to be able to demonstrate that the patient was fully informed and consent was freely given. Third party consent is therefore most likely to be appropriate only in cases where the patient lacks the capacity to consent and someone else has specific legal authority to make decisions on their behalf.

The British Medical Journal issues the following guidance on publications involving patients who lack capacity:

If the patient lacks the mental capacity to make a decision about publication our advice is that usually no one can give consent on behalf of the patient. Even if someone has this power, by means, for example of a health and welfare power of attorney, it has to be exercised in the
best interests of the patient. There may be some benefit to the patient in having his or her case described in a publication, but usually this is not obvious or certain. In such cases we will normally require any personal information to be anonymised or will not be able to publish it.\(^{20}\)

Based on the information available, third party consent must be considered carefully for the use of visual recordings for secondary purposes.

### 2.2.6 Consent for scientific research purposes

The separate ethical or legal obligation to gain consent from patients participating in research should not be confused with GDPR consent.\(^{21}\) Any regulations specific to research and clinical trials regarding ethical consent should be followed and the GDPR does not alter those requirements.

It is the responsibility of the nominated clinical trial lead or person responsible for conducting the research to identify both an appropriate lawful basis and a condition for the processing of special category data. There is no GDPR rule that says consent is required to process personal data for scientific research purposes, as there may be a more appropriate lawful basis [see Understanding data processing]. Further useful information on this subject is available on the ICO website (‘What is Valid Consent’).\(^{22}\)

### 2.3 Consent for non-clinical visual recordings

Patients, relatives, visitors and healthcare professionals may be asked to appear in visual recordings for publicity, promotion, demonstration or other non-clinical purposes. These visual recordings are often used in leaflets, posters or annual reports made available in hospital settings, in public places, such as libraries, and online. Consent is required from everyone that appears in a non-clinical visual recording.

As with clinical visual recordings, patients, relatives and visitors have the right to refuse to allow images to be made of them; during the recording of large groups, the person making the recording must make sure everyone has consented.

Accidental recordings of patients who have not given appropriate consent must be avoided, and should not be published under any circumstances. Staff have the right not to appear in such recordings and should be given the opportunity to withdraw unless key to the rationale for the recording.

Consent should be documented using a Model Release Form (Figure 4).
# Model Release Form

## Section 1: About you

<table>
<thead>
<tr>
<th>Full name:</th>
<th>Description and location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td>Date of recording:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

## Section 2: About the photo/video/audio recordings

<table>
<thead>
<tr>
<th>Description and location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

## Section 3: Conditions of use

I give [enter NHS body or organisation here] permission for photo / video / audio recordings of me to be taken, and I consent to publication or transmission, for the purposes of:

- News, media, and their associated print, radio and television channels
- [The organisation] website(s)
- Third party websites, including news media and other partner organisations
- [The organisation] or a third party’s social media channels – e.g. Facebook, Twitter, YouTube
- Publicity materials for recruitment, fundraising, and marketing
- Presentation and exhibition materials
- Other use as stated: ____________________________________________

Please tick as appropriate:

- [ ] I am over 18
- [ ] I am the responsible parent, guardian or carer

- I understand that the photo / video / audio recordings may be used in different formats by the NHS and partner organisations to promote awareness and understanding of care and treatment, and the work and values of the NHS.
- I understand that the photo / video / audio recordings will be stored electronically in accordance with Data Protection laws.
- I am aware that the photo / video / audio recordings will be held indefinitely. I can ask for the photo / video / audio recordings I appear in to be removed at any time by contacting [provide contact details here]. Although these will be removed upon request, I understand it may not be possible to stop their use completely.
- I know I will not be paid for allowing the photo / video / audio recordings to be taken or used. I am giving permission freely and know I will not get more or better treatment from the NHS because of it.

## Section 4: Your signature of consent

I am the person identified in Section 1. I understand the above request and give my consent.

Signed: __________________________ Date: __________________

Your parent or legal guardian’s signature

I am the parent or legal guardian of the person identified in Section 1. I understand the above request and give my consent.

Signed: __________________________ Date: __________________

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*Figure 4. Sample model release form.*
2.4 Patient / visitor visual recordings

Patients and/or visitors may occasionally wish to take photographs whilst in hospital, for example, proud family members taking photographs or filming newborn children within maternity. This should not be prevented, but patients and visitors should be aware that other patients and visitors may object to appearing in photographs. For this reason, it should be stressed that personal visual recordings should not have any other patients, visitors or staff appearing anywhere within the recording without permission. Refer to local policy for further information.

Where a patient has made a clinical recording of their own condition, and the recording is necessary for the care of that patient, then the recording can be stored as part of their healthcare record on the understanding that:

- Appropriate consent has been obtained
- The clinical content has been verified by the clinician / healthcare professional.

Refer to local policy to ensure that the process of sharing the recordings is safe in terms of data protection, confidentiality and IT security.

2.5 Patient access to visual recordings (health records)

Under data protection law, a patient has the right to request access to their health records, and hence their visual recordings. This request, commonly referred to as a subject access request (SAR) has to be made with the organisation that holds those records, i.e. the data controller. For hospital health records, that is the records or patient services manager at the relevant hospital authority.

If a patient would like to view a visual recording that you have made of them, you may be able to show them the visual recording, depending upon local policy; be mindful of other patient’s data which may be visible in the vicinity of the visual recording. It is not advisable to allow patients or visitors to take their own photograph of a visual recording that you have made due to risks concerning quality, misinterpretation, confidentiality and copyright.
Summary

Consent to make a visual recording for treatment/direct care purposes

- It is important to distinguish between consent to treatment and data protection consent issues. The separate ethical obligation to gain informed consent from a patient to treat them i.e. make a visual recording, should not be confused with consent to process personal data under data protection legislation.
- Consent to treatment should be obtained by the healthcare professional directly responsible for the person's treatment or test. It is recommended good practice for the healthcare professional making the visual recording to ensure that the patient consents to the recording being made.
- The patient has the right to refuse to have visual recordings made without it affecting their care or treatment; the healthcare professional making the referral should be informed in these instances.
- Refer to the detail provided in these guidelines when dealing with special circumstances such as patients who lack capacity, vulnerable patients, patients under anaesthesia, safeguarding children, pregnancy loss and neo-natal deaths, and deceased patients, and for recordings of specimens and ophthalmic imaging.
- The validity of consent to treatment (for direct care) does not depend on the form in which it is given. Consent to treatment can be expressed in writing, verbally or non-verbally. Explain to the patient why the recording will assist their care, what form the recording will take, and how it will be stored. The method of documenting and evidencing consent to a visual recording (for direct care use), is a Trust or Health Board decision.
- For consent to treatment to be valid the patient:
  - must have the capacity to make the decision
  - must have received sufficient information to make a choice
  - must be able to give their consent freely.

Consent to make or use a visual recording for secondary purposes

- Data protection legislation dictates that separate explicit consent is required for secondary use and data processing:
  - the request for consent must be clear
  - consent should be given by a clear affirmative act
  - the patient must feel able to refuse consent (without implications to their healthcare)
  - the patient must have the right to withdraw consent at any time.
References


14. NHS. Overview: Consent to Treatment, op. cit.

15. General Medical Council, op. cit.


19 Information Governance Alliance, op. cit.


22 Information Commissioner’s Office, op. cit.
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