

# Video Recording Consent Form for Medical Consultations

This **Video Recording Consent Form** ensures that patients provide informed permission before any recordings of medical consultations are made. This document outlines the purpose, usage, and confidentiality of any recorded sessions. It is essential for maintaining trust and legal compliance in healthcare settings.

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## Patient Information

Full Name:

Date of Birth:

Contact Number:

## Purpose of Recording

- The video recording will be used for:
- ☐ Treatment documentation
  - ☐ Medical teaching/training
  - ☐ Medical research (with identifying information removed)
  - ☐ Other (please specify):

## Confidentiality & Use

- Your video recording will be kept confidential and securely stored in accordance with applicable laws and regulations.
- The recording will not be shared with third parties without your explicit consent, except when required by law.
- You may withdraw consent at any time before or during the recording, without affecting your care.

## Consent Declaration

☐ I have read and understood the information above and voluntarily agree to the video recording of my medical consultation.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician/Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Note:** If you have any questions about this form or the recording process, please speak with your healthcare provider before signing.