

PATIENT CONSENT TO VIDEO RECORDING FOR ASSESSMENT PURPOSES

Date..... Workbook reference
number.....

Patient's
name.....
.....

Name(s) of person(s) accompanying patient to the
consultation.....
.....
.....

- Dr, whom you are seeing today, is hoping to make video recordings of some consultations. The videos are for part of an assessment procedure for doctors who are taking the Membership examination of the Royal College of General Practitioners (MRCGP), and who may also be undertaking an end-point assessment of their general practice training.
- The video is ONLY of you and the doctor talking together. Intimate examinations will not be recorded and the camera will be switched off at any time if you wish. All video recordings are carried out according to guidelines issued by the General Medical Council.
- Only people directly involved in the examination or assessment will see the video. It will only be used to assess the doctor whom you are consulting, and possibly for research, learning and teaching purposes. The tape will be securely stored and is subject to the same degree of confidentiality as your medical records. The tape will be erased as soon as practicable and in any event within three years.
- The security and confidentiality of the video recording are the responsibility of the doctor, College or assessment authority to whose care it is entrusted. If the tape is to leave the practice premises, it will be sent by registered post or Royal Mail Special Delivery, by personal messenger, or some other secure service.
- You do not have to agree to your consultation with the doctor being recorded. If you do not want your consultation to be recorded, please tell Reception. This is not a problem, and will not affect your consultation in any way. But if you do not mind your consultation being recorded, we are grateful to you. If you wish, you may view the tape recording before confirming your consent.
- If you consent to this consultation being recorded, please sign below. Thank you very much for your help.

TO BE COMPLETED BY PATIENT

I have read and understood the above information and give my permission for my consultation to be video recorded.

..... Date
.....
Signature of patient BEFORE THE CONSULTATION

..... Date
.....
Signature(s) of any person(s) accompanying patient to the consultation

After seeing the doctor I am still willing / I no longer wish my consultation to be used for the above purposes.

..... Date
.....
Signature of patient AFTER THE CONSULTATION

..... Date
.....
Signature of any person(s) accompanying patient to the consultation