**Consent Form for Recording**

**for Training Purposes**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Date**  |  |
| **Name of person(s)****accompanying patient** |  | **Place of Recording** |  |

We are hoping to make video/digital recordings of some of the consultations between patients and ACP (Primary Care Nurses) whom you are seeing today. The recordings are used by trainee ACP (Primary Care Nurses) to review their consultations with their trainers. The recording is ONLY of you and the ACP (Primary Care Nurse) talking together. Intimate examinations will not be recorded and the camera/recorder will be switched off on request.

All recordings are carried out according to guidelines issued by the General Medical Council and will be stored securely in line with the General Data Protection Regulation (GDPR). They will be deleted within one year of the recording taking place.

You do not have to agree to your consultation with the ACP (Primary Care Nurse) being recorded. If you want the camera/recorder turned off, 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, 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 recorded.

**Signature of patient BEFORE CONSULTATION:**

....................................................................................Date...........................................

**Signature of person accompanying patient to the consultation:**

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After seeing the ACP (Primary Care Nurse) I am still willing/I no longer wish my consultation to be used for the above purposes.

**Signature of patient AFTER CONSULTATION:**

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**Signature of person accompanying patient to the consultation:**

....................................................................................Date...........................................