



University Health Network

Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

MRN: 0759467 DOB: 20-October-1951 Sex: M



Visit Type: CP Visit: 50006412249

# PhotoGraphics

## Clinical Photography Request/Consent

UHN PhotoGraphics can photograph in clinics, inpatient units or at our studio, PMH 3B-405. Open 0900-1700 or by arrangement. Complete the requisition and call 16-4475 to make arrangements for clinic or inpatient unit photos. No appointment is necessary for studio photos but patients must have a completed requisition, including consent, with them. Studio photography is superior as we have control of lighting and background. We can accommodate full body to 2x magnification close ups.

**N.B. If dressings are to be removed/changed assistance should be available.**

### Clinical Photography Request

Date: 01/2/2022 Diagnosis: Pancreatic Acinar Carcinoma

Photos to demonstrate: paronychia of the legs

Diagram: Figures 1a & b in the manuscript which showed lower limbs of the patient described in the case report

Requested by: [redacted] PMH Program: DRO  DSO  DMO   
TGH Program: \_\_\_\_\_  
TWH Program: \_\_\_\_\_

To be completed by requesting physician/health practitioner or UHN PhotoGraphics staff.  
I confirm I have explained that images or recordings containing the patient's personal health information may be used for teaching and research purposes and answered any questions.  
Signature: [redacted] Date: 01/2/22

Please e-mail me copies:   
Chalen.lee@uhn.ca  
E-mail Address

**This request has no validity unless photography is performed by bona fide PhotoGraphics staff.**

### Consent for Use of Photography, Video or Audio Recording for Teaching or Research Purposes

I/We hereby authorize University Health Network (Toronto General, Toronto Western and Princess Margaret Hospitals) and its staff, employees and agents to take, exhibit, publish, broadcast and otherwise distribute images and/or recordings of the above named patient before, during and after treatment, upon the understanding that the University Health Network and its staff, employees and agents use said materials only for medical, scientific or educational purposes. I understand that I may withdraw this consent at any time upon written notice to the University Health Network. This will not affect my treatment and/or affiliation with the University Health Network in any way.

- I hereby waive any claim for payment arising from any use made of my image, recording or information.
- I hereby waive all claims against the University Health Network in connection with any use or disclosure made of my image, recording or other personal health information where I have consented to such use and disclosure.

**This document has been read over and explained to me and I clearly understand its meaning.**

Name of Patient/Substitute Decision Maker (please print)  
[redacted]

Please check & initial if you do not consent to identifiable photos:

Signature: [redacted]  
If Substitute decision maker, please state relationship

Dated this 1st day of Feb 2022

If signed other than by patient, relationship should be inserted beside signature of the person signing and proof of authority should be produced. If patient is under 18, parent or guardian must also sign beside signature of patient.

**This consent has no validity unless photography is performed by bona fide PhotoGraphics staff.**



