KLINICKÉ CENTRUM ISCARE
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Patient's consent
Use and handling of photo or video documentation

Given name and surname: .....

Date of birth/national identity number (if assigned): .....

Patient identification number (if assigned): .....

štítek/label

By signing this form below, I agree to the use of medical photo documentation, or evtl. video recording, of my treatment, in the following range (mark an X in the applicable box):

1. I consent for medical photographs/videos to be made of me before and after the procedure.
   ☐ YES ☐ NO

2. I agree to the use of the medical photographs/videos taken of me for the purpose of comparing therapy procedures and results.
   ☐ YES ☐ NO

3. I agree to the storage and archiving of photographs/videos I have been captured on for a period of 10 years from the date of signature of this consent.
   ☐ YES ☐ NO

4. I agree that the archived anonymized photographs/videos taken of me can be used for marketing purposes of ISCARE a.s.
   ☐ YES ☐ NO

The patient has the right to withdraw this consent in writing at any time (also in the form of e-mail communication).

In Prague: / 20 ***Patients Signature:***