I have given my express consent, on the condition that my identity will be kept confidential, for my personal photographs and/or videos to be taken and my visual contents that will appear during the shootings to be processed, shared and used by the mentioned health facility/healthcare professional within the framework of promotion and information in health services, and that I have read and understood this text. I agree.

Giving Consent/Legal Representative:

Name and surname :……..

Passport Number :……

Date :…….

Signature :……..

Receiver of Consent

Health Institution :……

Physician's Name and Surname :……

Position/Title :……

T.R. Identification number :……..

Date :……

Signature :……

DESCRIPTIONS

- **The patient has the right to withdraw this consent at any time.**
- **This consent form is for the processing, sharing and use of visual data and has no effect on the treatment process.**