

AUTHORIZATION FOR PHOTOGRAPHIC DOCUMENTATION

Instructions: This authorization must be signed by the client, or by the legal guardian or person responsible in the case of a minor or when the client is physically or mentally incompetent.

Client Name _____

Address _____

City/State _____ Zip _____

CONSENT:

BE IT KNOWN, that the undersigned hereby releases and authorizes Radiation Oncology Consultants, P.A. to incorporate photographs of and/or including the undersigned to utilized in the patient's medical record for documentation, educational purposes and for physician consultation.

Client Signature _____ Date _____

Legal Guardian/
Responsible Per _____ Date _____

Relationship _____ Witness _____

Radiation Oncology Consultants, P.A.

AUTHORIZATION FOR
PHOTOGRAPHIC DOCUMENTATION