Patient Name: ____ **Date of Birth:** ____________
First Name M.I. Last Name

MEDICAL PHOTOGRAPHY CONSENT

I consent to medical images and / or video being made of me or my child / dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images and results of my investigative tests may be:
(please tick below to show consent)

	Yes	No
…placed in my medical record for future treatment		
…electronically emailed to my treating health professional		
…used by health professionals for education and training		
…used in paper or electronic health publications		

PATIENT SIGNATURE: ____________________________________ **DATE:** _________________

____ **DATE:** _________________
Signature of Parent or other Legally Responsible Person

TREATMENT OBSERVATION CONSENT

Verity Radiation Therapy is an official Varian Reference Site. Periodically, we host visitors from other centers who wish to learn about our equipment. These are Radiation Oncology clinical personnel and administrators, and Varian representatives. A Verity Radiation Therapy staff member will ask your approval each time there is an outside observer present during your treatment. All patient information will be kept strictly confidential.

I ☐ DO ☐ DO NOT consent to periodic observers during my treatment
(Check one)

PATIENT SIGNATURE: ____________________________________ **DATE:** _________________

____ **DATE:** _________________
Signature of Parent or other Legally Responsible Person