ALPHA MED
PHYSICIANS GROUP, LLC

Photograph Consent Form

Patient Name: _____ Date: _____

I hereby consent to have an identification photograph, and photographs of the treatment position, taken. This is to be done by an Alpha Med Radiation Oncology employee. These photographs will be used for identification and treatment purposes only.

Signature of Patient: _____

Signature of Witness: _____

If the patient is a minor or unable to sign, please complete the following:

A) The patient is a minor _____ years of age.

B) The patient is unable to sign due to the following reason:

_____

_____

The undersigned certifies by his/her signature that he/she is duly authorized to accept the terms on behalf of the patient.

Signature of Responsible Party: _____

Relationship to Patient: _____

Witness: _____