marinhealth

Department of Radiation Oncology
1350 S. Eliseo Dr., Suite 100
Greenbrae, CA 94904
(415) 925-7326

[redacted]

DOS: 11/07/22
DEP: RDO

Photography Consent

I authorize the physicians and staff in the Department of Radiation Oncology to take an identification photograph of me and to photograph the area or condition for which I am being treated.

Both procedures are essential and necessary to the medical evaluation and treatment of my condition (and for scientific study of other patients similarly affected). Photos will become part of my radiotherapy record and will not be used in any publication without my knowledge or consent, although photographs may be used for medical teaching purposes without my name or face being identified.

Signed: X [redacted] Date: 11/7/2022 Witness: [redacted]
Patient / Guardian

Consent for Tattoos

I authorize the physicians and staff in the Department of Radiation Oncology to place tattoos around the treatment area for the purposes of accurate positioning and targeting.

Signe[redacted] Date: 11/7/2022 Witness: [redacted]
Patient / Guardian

Radiation Therapy Consent

I authorize Dr. [redacted] and such qualified staff as he/she may designate to administer radiation therapy treatments to me and continue such treatments as deemed advisable.

All procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

- The nature of the procedure, including other care, treatment, or medications.
- Potential benefits, risks, or side effects of the procedure, including potential problems that may occur during recuperation, both short term and long term.
- The likelihood of achieving treatment goals.
- Reasonable alternatives and relevant risks, benefits, and side effects related to such alternatives, including the possibility of not receiving care or treatment; and
- Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed procedure.

Except in cases of emergency, procedures will not be performed until you have had the opportunity to receive this information and have given your consent.

Signed: X [redacted] Date: 11/7/2022 Witness: [redacted]
Patient / Guardian

Consent for Pregnancy Testing

For women 50 years of age and under:

I authorize the physicians and staff in the Department of Radiation Oncology to perform a pregnancy test to ensure I am not pregnant before proceeding with treatment planning. ☐ YES ☐ NO

I refuse pregnancy testing: ☐ Tubal ligation or oophorectomy ☐ Menopause ☐ Not sexually active

I understand that birth control is of the utmost importance during treatment, as fetal development during this time could be significantly jeopardized if exposed to radiation. I have been counseled about the importance of avoiding pregnancy during radiation treatment, and I release Marin Health Medical Center from any liability should I become pregnant during this time.

Signed: _____ Date: _____ Witness: _____
Patient / Guardian

I have accurately and completely read the foregoing document to the patient or legal representative in their primary language: _____. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

Translator's Signature: _____ Date: _____ Time: _____

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Department of Radiation Oncology
1350 S. Eliseo Dr., Suite 100
Greenbrae, CA 94904
(415) 925-7326

[redacted]

IOS: 8/15/22
IEP: RDO

APT MD: Mhmc Rad Onc Ct

Photography Consent

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Signed: [redacted] Date: 8/15/2022 Witness: [redacted]
Patient / Guardian

Consent for Tattoos

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Patient / Guardian

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[redacted]
4001952130 00095859
[redacted] RDO
Patient: _____ ADM POEN, JOSEPH C RECURRING OP

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