

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

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: _ 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 Signe Patient / Guardian Radiation Therapy Consent I authorize Dr. 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 . 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 . 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 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 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:

Patient / Guardian

I have accurately and completely read the foregoing document to the patient or legal representative in their primary language:

the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

He/she understood all

Translator's Signature: C:\Users\neylonk\Desktop\photoconsent.english0320.doc6/9/20202;24 PM



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Signed:Patient / Guardian			Dat	re:		Windows			
I have accurately and completely the terms and conditions and ack	read	the foregoing docu ledged his/her agre	men	t to the patient on thereto by sig	or legal ning the	representative in document in my	their p	primary language: He/sine understood ence.	all
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