compass oncology
THE NORTHWEST CANCER SPECIALISTS

Consent for Patient Photography

I hereby give my consent to be photographed:

Name: _____

DOB: _____

_____ Yes _____ No

I understand that my photograph is being taken for identification purposes only. I understand that Compass Oncology – The Northwest Cancer Specialists will retain ownership rights to these photographs and they will become a permanent part of my medical record for as long as that record exists. Images that identify me will be released only upon written authorization from me or my legal representative.

Date: _____ _____
Patient Signature

_____
Patient Signature

Date: _____ _____
Witness Signature