CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

ACKNOWLEDGEMENT OF PHOTOGRAPH
CONSENT TO EMAIL

Patient Name:	**Date of Birth:**

I, _____ understand that as part of my treatment for safety and identification purposes my
(Print Name)
picture will be taken for placement in my medical record. I understand that ownership of this photograph will be retained by Central Alabama Radiation Oncology, LLC. Images that identify me will be released to outside agencies only if a written authorization is signed by me or my legal representative.

_____ **(initial)** I hereby acknowledge that my picture will be taken on my initial visit and as deemed necessary by my attending physician and/ or his associates.

_____ **(initial)** I authorize Central Alabama Radiation Oncology, LLC to communicate via email to me regarding missed appointments, reminders, education material etc…

Email Address: _____

_____ _____

Patient's Signature **Date**