Prosthetic Care Facility of Virginia

Patient Consent Form

I hereby authorize and give permission to Patient Care Facility of Virginia or its otherwise entitled branch offices, to interview, photograph, videotape, and/or film

_____

(Name of Patient)

and to use such materials, including medical information relevant to my rehabilitation program, in any manner which assists my treatment and/or evaluation process, or which helps to increase public awareness and knowledge regarding the fields of orthotics and prosthetics.

I also permit, unless specifically stated otherwise, the use of my name and other identifying information, in conjunction with the release of such materials.

Date _____ Signature _____

(Patient or Parent or Guardian of Minor Patient)

Confidentiality Waiver

I hereby grant permission to Patient Care Facility of Virginia and its affiliate offices, to use my name, personal and medical information, and photograph, video, film, and/or x-rays, in the newsletter, and to release such materials to professional orthotics and prosthetics publications as well as the general print and electronic media to advance public knowledge and awareness of the field of orthotics and prosthetics.

Date _____ Signature _____

(Patient or Parent or Guardian of Minor Patient)