Pioneer Neurology and Sleep

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I request and give permission to my physician, Dr. _____,
And to such other physician and persons as may be needed to assist my physician to complete the following procedure: _____
My physician has explained to me the general way that this procedure will be performed, the possible complications involved, and possible alternative methods of treatment. I understand that rarely some patients may develop skin abrasions or skin reactions with electrode application. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me concerning the results of this procedure. I, therefore, consent to the procedure as described above.

I also authorize the taking of photographs or videotapes when completing the above procedure. I understand that these photographs will only be used for diagnostic purposes and are confidential information to be viewed only by appropriate physicians and technicians affiliated with ***Pioneer Neurology & Sleep****. I understand that I may revoke this consent at any time but my authorization for the taking of photographs is a necessary part of this procedure.*

_____ _____
Witness *Patient's Signature*

_____
Date *Time*

The patient is unable to consent because: _____

_____

I, therefore, consent for the patient.

_____ _____
Signature *Relationship to Patient*

_____ _____
Witness *Date* *Time*