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**Parent's Permission to Produce Radiation Oncology Records**

**For Keloid Radiation Registry (SLIRB # 11-184)**

I, ....., parent / guardian of .....  
date of birth, ..... give my permission for .....,  
to give all of radiation treatment records of my child to Dr. Michael Tirgan. My child is enrolled in  
the Keloid Radiation Registry Study. Dr. Tirgan is the Principal Investigator of this study. You can  
learn more about this study by visiting [www.Keloid-Radiation.com](http://www.Keloid-Radiation.com).

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I understand that:

- I do not have to give my permission to share these records.
- If I want to take away the permission for Dr. Tirgan to get these records, I need to talk to Dr. Tirgan or his staff person and sign a separate form.
- This form is only good for 3 months from the date I sign it.

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Patient's Name: .....

Parent's Name: .....

Parent's Signature .....

Date: .....

Relationship To Patient: .....