



Patient ID No.: _____
(If unknown, leave blank)

Date: _____

I hereby authorize and direct _____, M.D. with associates or assistants of his/her choice to perform
(Doctor's Name)
the following procedure _____ on _____
(Procedure Name) (Patient Name)
as we have agreed upon.

I further authorize the Radiologist (s) to perform any other procedure (s) that their judgment may dictate to be necessary or advisable should an unforeseen circumstance arise during this procedure. The details of the procedure have been explained to me in terms that I understand. I also understand the risks, if any, of refusing the procedure. I am advised that though no complications are expected, they cannot be anticipated and therefore warrants no guarantee, either expressed or implied, as to the results of the procedure. The Radiologist has answered all of my questions.

The Radiologist has explained to me the most likely complications or problems that might occur during this procedure and during the healing period, if any, and I understand them.

The Radiologist has offered, in detail, the less likely complications for which, even if rare, could occur.

Please check one:

- I do wish to have these described to me
- I do not wish to have these described to me

I understand there is a remote risk of death or serious disability with any procedure.

I authorize and direct the above-named Radiologist, with his/her associates, to provide such additional services as they may deem reasonable and necessary including, but not limited to, the administration of any anesthetic agent and the services of the x-ray department and their laboratories.

I further consent to the administration of such anesthetics as may be considered necessary. I recognize that there are always risks to life and health associated with anesthesia and such risks have been fully explained to me.

Please check:

- I certify that I have read and that I understand this consent and all blanks were filled in prior to my signature.

Signature of Patient or Legal Guardian/Representative Signature

Date

Witness

Relationship to Patient