Patient Consent to X-Ray / Bone Density / Ultrasound / MRI / CT

I authorize the performance of Mammogram, Bone Density, X-Ray, CT, MRI and/or ultrasound examination of myself which my physician may consider necessary or advisable in the course of my examination and treatment. I understand that most of these exams will expose me to ionizing radiation.

Patient's Signature: _____ Date _____

Printed Name: _____ Date of Birth: _____

If Patient is a Minor:

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray, CT, MRI and/or ultrasound of this minor which my physician may consider necessary or advisable.

Signature of Parent/Guardian: _____Date: _____

_____
Relationship to Patient

Females:

Regarding Possibility of Pregnancy:
This is to certify that, to the best of my knowledge, I am not pregnant, and Executive Imaging, LLC has my permission to perform diagnostic x-ray or CT examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Patient's Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____