



X-RAY CONSENT FORM

Patient Name (Print): _____ **D.O.B :** _____

During your examination, the medical provider may feel that x-rays will be needed to diagnose your condition. In addition, they may be required to administer appropriate treatment. By signing below, I consent to having the diagnostic x-rays performed, which the medical provider has determined is clinically necessary.

FOR WOMEN ONLY

I certify that, to the best of my knowledge, I am NOT pregnant. The provider has my permission to perform diagnostic x-rays to properly diagnose and provide appropriate treatment. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous and pose a risk to pregnancy.

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams.

CONSENT TO X-RAY A MINOR

I am a parent or legal guardian of _____, and hereby authorize the performance of diagnostic x-rays of said minor. The provider has requested the x-rays for further diagnostic purposes. At this time, I know of no other condition which the taking of x-ray would further complicate.

Parent / Guardian Signature: _____ **Date :** _____

Patient Signature: _____ **Date :** _____