CLARKSVILLE
IMAGING
CENTER
OPEN MRI • CT • ULTRASOUND

2320 Wilma Rudolph Blvd.
Clarksville, TN 37040
(931) 245-OPEN(6736)
Fax (931) 245-6738

Patient Name _____

Medical Record # _____

CONSENT FOR CONTRAST MEDIUM DIAGNOSTIC PROCEDURE

1. I hereby request and authorize Clarksville Imaging Center and their medical staff to perform the following Diagnostic Procedure: _____

2. I understand the above named diagnostic procedure has been ordered by my physician, _____ _____.

3. I have been informed of the risks and possible consequences involved, and that unforeseen results may occur.

4. I have read and fully understand this entire consent form.

5. I further acknowledge that all the blank spaces have either been completed or crossed off prior to my signing.

Signed: _____ Date: _____
(Patient or Nearest Relative)

Witness: _____ Date: _____
(Technologist)

HISTORY

_____

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CONSENT FOR CONTRAST MEDIUM DIAGNOSTIC PROCEDURE