VALLEY IMAGING CENTER
22281 Highway 72 E Suites B & C
Athens, Al 35613

Patient Name____

DOB__________________________ Doctor_________________________

IV CONTRAST PROCEDURE AUTHORIZATION

As a patient, you have the right to be informed of the procedure you are to have completed. You have the decision to agree to or refuse the procedure, when using IV contrast.

I voluntarily give my medical information such as allergies, especially any allergic reactions to medications, to the best of my knowledge. Allergies follow:

____

____

I voluntarily request Dr. Cannon and staff to provide healthcare as may be necessary to treat my condition, which is explained as:

____

____

I understand the diagnostic procedure and consent and authorize these procedures:

____

I understand the injection procedure and consent and authorize the injection of ______ cc's of _________________________ in the ______________ arm.

I also request any tissues removed be disposed of by Valley Imaging Center accordingly.

I understand that there are risks such as infection, blood clots, allergic reaction, pneumothorax, and even death, involved with performances of diagnostic services.

I understand the risks that maybe affiliated with my procedure, such as: respiratory problems, brain damage or even death, and request the use of anesthetics for relief from pain during my procedures I may have completed,.

I have been given a chance to ask any questions that I may have. I feel I have enough information to give informed consent.

____________________________ ____________________________

PATIENT SIGNATURE **WITNESS SIGNATURE**

_______________ __________ ____________________________

DATE **TIME** **PHYSICIAN SIGNATURE**