Consent to Undergo Radiographic Imaging

I hereby consent to the taking of diagnostic records, including x-rays, to the above doctor(s) and, where appropriate, staff providing services prescribed by the above doctor(s) for the individual named below. I fully understand all of the risks associated with the treatment.

Authorization for Release of Patient Information

I hereby authorize the above doctor(s) to provide other health care providers, including an Oral and Maxillofacial Radiologist, with information regarding the below named individual for medical and dental purposes. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any further release by the individual receiving this information.

Consent to Use of Records

I hereby give my permission for the use of obtained records, including images, made in the process of examinations for purposes of professional consultations, research, education, or publication in professional journals.

Medical Background

Is there any medical condition for which you are currently under treatment that you feel we should know about prior to obtaining the radiographic image(s)? ___ YES ___ NO

If yes, please explain _____

_____

_____

Emergency Contact

Name _____

Relation _____

Number _____

_____

Patient Name (Print)

_____ _____

Patient/Parent/Legal Guardian Signature Date

_____ _____

Witness Date