

HOSPITAL  
FOR  
SPECIAL  
SURGERY

CONSENT FOR RADIOLOGIC OR IMAGING PROCEDURE



535 East 70<sup>th</sup> Street  
New York, NY 10021

I hereby give authorization and consent to Hospital for Special Surgery, its Radiology staff, and assistants/associates to perform/provide the following procedure(s) /invasive test(s)/ and /or treatment(s):

\_\_\_\_\_  
\_\_\_\_\_  
(NAME /DESCRIBE PROCEDURE)

upon \_\_\_\_\_  
(NAME OF PATIENT)

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such procedure, as well as the alternatives if the procedure is not performed, have been explained and discussed with me. I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with anesthesia, use of medication, medical procedures, and treatments, which can cause adverse consequences not ordinarily anticipated in advance. These adverse consequences and complications include, but are not limited to, allergic reaction, bleeding, infection, nerve damage (temporary or permanent numbness/weakness, or altered sensation) and death.

I further grant permission for the use of such tissues and/or fluids, as it may be necessary to remove during said procedure, for the purpose of pathological diagnosis and thereafter for the advancement of medical knowledge and/or education, and their disposal, at this Hospital or at such other institutions as this Hospital may designate.

I consent to the photographing, videotaping, televising, or other observation of the procedure for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity remain confidential.

I confirm that I have read and fully understand the above and have been given an opportunity to ask any questions, and all my questions have been answered fully and satisfactory by  
Dr. \_\_\_\_\_.

I represent to the radiology staff and Hospital For Special Surgery that I am eligible to give this consent.\*

Signature of patient/parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

\* If the patient is under 18 years of age, the permission of the patient's parent or legal guardian must be obtained, unless the patient has married or is the parent of a child.