HOBOKEN RADIOLOGY

Providing a clearer image of health

79 Hudson Street, Suite 100 Hoboken, NJ 07030

TEL: 201-222-2500 FAX: 201-469-0555

SONOHYSTEROGRAM CONSENT FORM

PATIENT INFORMED CONSENT FOR SONOHYSTEROGRAM

I,_____ am _____ years old and I am NOT
*(**Patient Name** -please print clearly)* *(**Patient Age**)*
pregnant. I am aware and understand that if I am pregnant and have this procedure, I could very well have a miscarriage or harm the fetus.

I understand the above and hereby release Hoboken Radiology, LLC, the attending physician, its personnel and employees, from any responsibility whatsoever for any harmful effects I may incur or affects my fetus may incur as a result of this procedure, if in fact I am pregnant. I understand further that this RELEASE shall be binding upon my heirs, executors, administrators and assigns.

The benefits, alternatives and risks of this procedure have been explained to me to my satisfaction and understanding. All questions regarding this procedure have been answered.

I give my consent to having the SONOHYSTEROGRAM performed.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Witness Signature

WHEN PATIENT IS A MINOR OR OTHERWISE UNABLE TO SIGN ON HER OWN BEHALF

_____ _____
Name of Legally Authorized Representative Signature of Legally Authorized Representative
(Please print clearly)

_____ _____
Relationship to Patient Reason for Patient's Incapacity
(Please print clearly) ***(Please print clearly)***

_____
Witness Signature