

McLAREN IMAGING CENTER  
501 S. Ballenger Hwy., Suite B Flint, MI 48532  
(810) 342-4800  
**GENERAL CONSENT**

Physician: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**This paper serves as a legal document concerning the following procedure:**

My signature on this document indicates my willing consent to the above named diagnostic procedure.

The nature, benefits, as well as the risks of the procedure, including the possibility of contrast reactions, have been fully explained to me. The above named physician has answered any of the questions I had to my satisfaction.

I authorize the named physician or his designees to initiate the proper and immediate course of action or treatment that may be necessitated if unforeseen conditions or events occur.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_\_\_

Time Out: \_\_\_\_\_

Technologist Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Post Instructions**

Time: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Technologist Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

