

**CONSENT FOR MRI PROCEDURE WITH CONTRAST**

I, the undersigned, hereby authorize the Doctor(s), Radiologist(s), their Associates, Hospital, or Facility listed below to perform the following procedure:

\_\_\_\_\_ on \_\_\_\_\_  
(Name of Procedure) (Name of Patient or Myself)

NAME OF DOCTOR: \_\_\_\_\_

NAME OF FACILITY: **Gainesville Open MRI Center, Inc.**

And to perform any other procedure(s) which the Physician may, in their judgment, deem advisable and/or necessary during or following this procedure, if there not time to consult with me further without additional risk to my health.

I understand that this procedure includes the injection of contrast material into my veins and taking cross-sectional images without x-rays.

I have been informed of occasional side effects of the contrast media and the possibility of complications, if any, have been fully explained to me.

I agree to release the provider of MRI equipment, its officers, directors, agents, assigns, subsidiaries and employees, my Physician, his assistants, the facility and its employees from any and all liability, claims, actions, proceedings, damages and expenses (including reasonable attorney fees) from any unforeseen consequences of my participation in an MRI CONTRAST EXAM. I understand that only Physicians or Professional Facility personnel may inject any required contrast medium or otherwise into patients.

---

The foregoing consent was read and discussed with me, and I give my consent freely with full understanding. I have been given the opportunity to ask any questions before signing this paper, and all my questions have been answered to my satisfaction.

PATIENT OR PERSON AUTHORIZED TO CONSENT: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

LIST OF KNOWN ALLERGIES: \_\_\_\_\_

---