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## Patient Consent for Hysterosalpingogram and Sonohysterogram

I hereby consent to and authorize Park Avenue Radiologists, PC, its doctors, technicians and medical personnel to perform a

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Print Type of Study

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

I have completed the patient questionnaire and all information with regard to my medical history.

The nature and purpose of this procedure has been explained to me and I understand that there will be an insertion of a flexible tipped catheter into my body.

The risks of injury, infection, bleeding and other complications, despite precautions, have been explained to me. All questions that I may have in reference to this procedure and the associated risks have been explained to my satisfaction.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Patient or Guardian or Person Authorized to Consent For the Patient

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

If for any reason following this procedure you experience discomfort or other symptoms, please call us or your referring physician.

### FOR OFFICE USE ONLY

\_\_\_\_\_  
Signature of Physician

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

\_\_\_\_\_  
Signature of Technologist

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