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PATIENT NAME _____ DATE ____/____/____ TIME: ____:____

Patient Consent Form for Fine Needle Aspirations and Core Biopsy Procedure

I hereby consent to and authorize Park Avenue Radiologists, PC, its doctors, technicians and medical personnel to perform a Fine Needle Aspiration or Core Biopsy of my _____
 (Specify Body Part)

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

The nature and purpose of this procedure has been explained to me and I understand that there will be an insertion of a needle into my body so that tissue and or fluid can be removed.

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