MRI- INFORMED CONSENT FOR IMPLANTS / DEVICES

Patient Name____**Date of Birth** _________________

Your physician has recommended that you undergo an MRI procedure to be performed by Alliance HealthCare Services or one of its affiliates or subsidiaries (collectively, “Alliance”). You have advised your physician and the MRI staff that you have an implanted object or mechanical/electrical device which meets one of the following:

- ☐ Contraindicated- Explain: ____
- ☐ Unable to confirm MRI implant or device safety at time of scan
- ☐ Specific conditions required for MRI cannot be met- Explain:______________________________________

MR Conditional Devices are those which pose no known hazards in a specified MRI environment if specified conditions for use are followed. The conditions and specifications are provided by the device manufacturer. Conditions that define the MRI environment include the strength of the magnet, the magnetic field, radiofrequency fields and device heating reports. Additional conditions, including specific configurations of the item may be required.

The benefit of having the Procedure is to provide your physician with additional diagnostic information to assist him/her in either (i) diagnosing the existence of or absence of a medical condition; or (ii) the treatment of a medical condition. The undersigned radiologist (“Supervising Physician”) is responsible for supervising the proposed scan, and determining if the exam may be performed.

You have the right to be informed of the effect that the Procedure may have on your personal health, the object/device, the risks, benefits and nature of the Procedure and any alternative procedures. Please read this form carefully and ask any questions you may have before you decide whether to give your consent for the Procedure.

***Acknowledgement*:** By signing this form, you agree that you (i) have read and understood the information in this form; (ii) have been verbally informed about potential effects of the Procedure(s) on the implanted object/device; (iii) have had an opportunity to ask questions and have received all the information you desire concerning the effect on your personal health; (iv) understand the potential risks and benefits of the Procedure(s) and the potential effect of the Procedure(s) on your personal health; (v) have been informed of alternative diagnostic options available to you; (vi) understand that you may revoke your consent at any time without effecting future treatment; and (vii) consent to and authorize Alliance to perform the Procedure(s).

The undersigned Patient and Physician understand that Alliance would provide the Procedure(s) to Patient only if Patient, as well as Physician, release Alliance from any and all claims arising out of the Risk(s). Accordingly, the undersigned Patient and the undersigned Physician do hereby release and forever discharge Alliance, its insurance carriers, and all of their respective officers, employees, and agents, from any and all claims and causes of action, and all liability whatsoever, arising out of the Risk(s).

THIS RELEASE IS INTENDED TO, AND DOES COVER, ALL DAMAGES AND LOSSES WHETHER KNOWN TO THE UNDERSIGNED AT THE TIME OF THE EXECUTION OF THIS RELEASE OR NOT.

________________________	________________________	__________
Patient or Legal Representative Signature	*Print Name and Authority (If legal representative)*	*Date*
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Radiologist Signature	*Print Radiologist Name*	*Date*
________________________	________________________	__________
Technologist Witness Signature	*Print Technologist Name*	*Date*

Site/Hospital Name____