RADIOLOGIE BADEN-BADEN

Dr. Klaus Meier Dr. Andreas Stoldt Dr. Stefan Ladner Prof. Christian Plathow, M.Sc. PD Dr Moritz Palmowski

Quality Management **RÖNTGEN**

Declaration of consent: X-ray

First name and surname: **Patient number:**

Date of birth:

- **Have you or your child ever had an X-ray taken in the same body region?**
  - **YES**
  - **NO**
  - **If yes, when and where?** _____
- For women of childbearing age: Could you be pregnant?
  - **YES**
  - **NO**

I **consent** to the X-ray examination

I **also** agree that the findings be forwarded to other attending physicians, professional associations, and health insurance companies. Until further notice, I hereby consent that my treating physicians obtain findings from other service providers and forward findings on me to other attending physicians in accordance with § 73 (1b) of Social Code Volume V.

- **YES**
- **NO**

A copy of this medical history will be granted to you on request.

Date: **Signature:**

Signature (medical assistant):