Consent for radiologic services and acknowledgement of the scope of services

Notice: The following is not intended as legal advice. Not all jurisdictions may recognize the ability to take diagnostic records without creating a duty to diagnose. Please check with a local attorney for confirmation.

I, _____(name of patient), hereby consent to _____(name of orthodontist or office) performing radiologic services as ordered and recommended by my dentist, _____(name of dentist).

The risks of submitting to radiologic services, including X-rays, have been fully explained to me by my dentist. I have discussed the need for these radiologic services with my dentist and agree to undergo the radiologic services recommended by my dentist. I understand _____ (name of orthodontist or group) has made no recommendations regarding the need for these radiologic services or the type of radiologic services to be performed.

I understand that _____(name of orthodontist or orthodontist's office) will provide **no professional interpretation** of the radiologic images obtained on the order and recommendation of my dentist. I further understand that _____ (name of orthodontist) will **provide no treatment and will make no recommendations for treatment** based on these radiologic studies to either me or my dentist. I understand that _____ (name of orthodontist or orthodontist's office) is only providing a technical service to my dentist by allowing my dentist to utilize the radiologic equipment operated by _____(name of orthodontist or orthodontist's office). I hereby authorize _____ (name of orthodontist or group) to provide my radiologic studies and related health care information to my dentist for his/her sole professional interpretation.

I understand that my dentist will be billed by _____ (name of orthodontist or orthodontist's office) for the provision of the technical service of obtaining the radiologic services ordered by my dentist, and that I will be billed directly by my dentist for these services.

_____ _____

Signature of Patient or Guardian Date

I have the legal authority to sign on behalf of:

_____

Name of patient