Gulf Coast MRI & Diagnostics Clear Lake
Background Information on Pregnancy Issues and Release

As a female of childbearing age, you must be aware that harm or damage may occur to any unborn fetus during certain radiological procedures performed at Gulf Coast centers. Therefore, if you are pregnant all precautions must be taken to prevent harm to the unborn fetus, which typically includes not performing any radiological procedures on the pregnant mother.

In order to protect you, and to prevent any such potential harm, it is required that you provide accurate and truthful information about all pregnancy related information including the following:

- ☐ I have not been sexually active.
- ☐ I am on birth control.
- ☐ I am pregnant.
- ☐ I am not pregnant; LMP:_____

I attest that all of the information that I have provided to Gulf Coast Centers is truthful and accurate. If any such information is not accurate, I will hold Gulf Coast centers, my physician_____, and all of their affiliates, harmless and not responsible for any and all claims for damages of any type (this expressly includes all claims for negligence) arising from any alleged harm to an unborn fetus or any harm to me as a result of miscarriage and/or other harm to the unborn fetus.

I **DO** believe that I may be pregnant, and I understand that it is my obligation to obtain a pregnancy test before any radiological or MRI tests are performed by Gulf Coast MRI & Diagnostics.

Date: _____ Time: _____ AM PM

_____ _____

Signature of Patient or Other Person Legally Authorized to Consent for Patient *Relationship to Patient*

_____

Witness Name

I **DO NOT** believe I may be pregnant, therefore, I refuse to submit to pregnancy testing and accordingly, I release and hold harmless Gulf Coast MRI & Diagnostic, together with their affiliates from any damages or liability which may result from the radiological or MRI services at issue, including any claims for negligence or any other claim that I may have in law or in equity.

Date: _____ Time: _____ AM PM

_____ _____

Signature of Patient or Other Person Legally Authorized to Consent for Patient *Relationship to Patient*

_____

Witness Name