

[Your Practice Name]
[Your Practice Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]

[Patient's Name]
[Patient's Address]
[City, State, Zip Code]

Dear [Patient's Name],

Subject: Consent for Ultrasound Examination

I, [Patient's Name], hereby give my consent to [Your Practice Name] to perform an ultrasound examination as recommended by my healthcare provider.

I understand the nature and purpose of the ultrasound procedure and the potential benefits it may provide in diagnosing and monitoring my condition. I have had the opportunity to ask questions and have received satisfactory answers regarding the procedure.

I acknowledge that there are no known risks associated with the ultrasound, and I understand that I can withdraw my consent at any time prior to the procedure.

I confirm that I am the patient or the legal guardian of the patient named above and have the authority to grant this consent.

Patient's Signature: _____

Date: _____

Guardian's Signature (if applicable): _____

Date: _____

Thank you for your cooperation.

Sincerely,

[Your Name]
[Your Title]
[Your Practice Name]