956.621.0195 tel
956.621.0115 fax
1313 E. Alton Gloor, Ste. A
Brownsville, Texas 78526

www.babytimeultrasound.com
babytimeultrasound@yahoo.com

AUTHORIZATION, VERIFICATION, & REFERAL FORM

Client's Name: _____

IS AUTHORIZED TO HAVE AN ELECTIVE 3D/4D ULTRASOUND(S) AT BABYTIME 3D/4D ULTRASOUND STUDIO, INC. I WILL NOT BE INTERPRETING THIS ULTRASOUND WITH ANY MEDICAL DIAGNOSTIC INFORMATION AND AM PROVIDING AUTHORIZATION SOLELY AS PER PATIENT'S REQUEST.

Doctor's Information

Name: _____

Address: _____

Phone: _____ Fax: _____

Printed Name: _____

Signature: _____ Date: _____

PATIENT'S CONSENT TO RELEASE INFORMATION

I REQUEST THAT THE ABOVE NAMED PHYSICIAN OR HIS/HER STAFF PROVIDE AUTHORIZATION TO HAVE AN ELECTIVE 3D/4D ULTRASOUND AT BABYTIME 3D/4D ULTRASOUND STUDIO, INC. I FURTHERMORE, GIVE MY AUTHORIZATION TO HAVE THE ABOVE INFORMATION RELEASED AND PROVIDED TO BABYTIME 3D/4D ULTRASOUND STUDIO, INC. VIA: FAX (956)621-0115 (OR) EM: BABYTIMEULTRASOUND@YAOO.COM

Print Name: _____

Signature: _____ Date: _____