650 N Sam Houston Pkwy, Suite 553, Houston TX 77060
Phone: 281-999-0003 Fax: 281-668-5218

ULTRASOUND AUTHORIZATION

Client's Name_____is authorized to have a 3D/4D Ultrasound(s) at Baby Steps Ultrasound facility. I will not be interpreting this ultrasound and am providing authorization solely at the patient's request.

DOCTOR'S INFORMATION

Doctor's Printed Name_____Phone #_____

Address_____City, State, Zip _____

Doctor's Signature_____Date_____

PATIENT 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 Baby Steps Ultrasound facility. I further provide authorization to have the above information released to Baby Steps via mail, fax, or in person.

Thank you,

Patient Signature_____Date_____