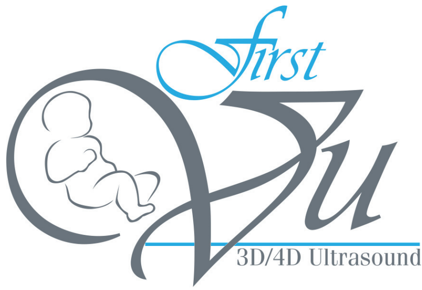

First Vu Imaging
3108 Midway Road - Ste. 201
Plano, Texas 75093

Tel: (972) 398-1900
Fax: (972) 294-3778

info@firstvuimaging.com
www.firstvuimaging.com

ULTRASOUND AUTHORIZATION

Name: ____

Date of Birth: ______________________________________

is authorized to have 3D/4D Ultrasound(s) at First Vu Imaging. I will not be interpreting this ultrasound and am providing authorization solely at the patient's request.

Healthcare Provider

Name: ____

Address: ____

Phone: ____

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 First Vu Imaging. I further provide authorization to have the above information released to First Vu Imaging via mail, fax or in person.

Thank you,

Print Name: _______________________________________

Signature: ______________________________ Date: __________