Baby Love Ultrasound
Create a Lasting Memory

Baby Love Ultrasound
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ULTRASOUND AUTHORIZATION

Name: _____

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

Doctor's Information

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

Thank you,

Print Name: _____

Signature: _____ Date: _____