



**Blooming Baby**  
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## ULTRASOUND AUTHORIZATION

**Name:** \_\_\_\_\_

is authorized to have a 3D/4D Ultrasound(s) at Blooming Baby. 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 Blooming Baby. I further provide authorization to have the above information released to Blooming Baby via mail, fax or in person.

Thank you,

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_