5860 S. Cooper #100
Arlington, TX 76017
(O) 817-465-8439
(F) 888-968-8439

Elective/Limited Diagnostic Ultrasound

Date: ___________________ Doctor: ________________________

Patient's name: ____ **D.O.B:** _____________

The above named patient is under our care for her pregnancy. She has requested a release for a 2D-3D/4D limited diagnostic scan for personal purposes.

The Patient has or will have a diagnostic ultrasound exam performed or ordered by our practice if medically indicated.

She may have the elective 2D-3D/4D Ultrasound exam performed by any provider certified to perform such exams by the State of Texas.

This 2D-3D/4D ultrasound is by clients request and is **not** considered medically necessary.

This permission to perform the 2D-3D/4D ultrasound in no way constitutes a physician's order for service this is acknowledging that she has the right to choose this service.

Any charges for these services will be the sole responsibility of the client.

Thank you

_______________________________ ______________

Midwife/Physician Signature **Date**