Woman's CLINIC
A Professional Association
Obstetrics/Gynecology

Physician Authorization

_____
Date

Dr. _____, please be informed that your patient,

_____ (DOB: ____-____-_____), has scheduled an

elective 3D/4D OB sonogram at the Woman's Clinic on _____/_____/_____.

Our services are not intended as a replacement for a full diagnostic maternal / fetal survey.

We require all of our patients to receive prenatal care and that their Obstetrician is informed that an elective ultrasound has been requested. We have highly trained ultrasound technicians using the latest technology in accordance with FDA regulations. We provide a nurturing atmosphere where fetal cardiac activity and fetal number and gender are verified, if possible.

If this is not your patient, you have any questions regarding our services, or do not wish your patient to use our services, please contact us. This service will be provided at no cost or liability to you or your office. You will be notified immediately if any problem is seen during our session.

I am authorizing this elective ultrasound at the Woman's Clinic.

_____
Physician's Signature

_____
Name of Clinic and Telephone Number

_____
Special Instructions

******Please return this form to our office******
731-422-4642 (office)
731-422-2277 (fax)