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4-D Ultrasound Prescription

Print this written permission form and ask your physician to sign it, then call our office at (316) 462-2000 to schedule your session.

Physician Name (please print or type) ______________________________

______________________________ ______________
Physician Signature Date

I understand that this is not a diagnostic procedure and that a radiologist will not interpret these images or provide a written report to my physician. I further understand that by signing this document, I am waiving all responsibility or liability by Anatomi Imaging radiologists, or my physician, including but not limited to any future diagnosis which might be made at a later date from images taken during this session. I also understand that a permanent record of this session will not be kept by Anatomi Imaging.

Patient Name (please print or type) ______________________________

______________________________ ______________
Patient Signature Date