MTV IR

Authorization / Consent for Patient Records

Patient Name: _____

Patient Signature: _____

Patient DOB: _____

Patient Address: _____

Patient Phone Number: _____

Requesting Physician: _____

Please release Lab / CT / MRI / PET / US Imaging and Reports:

_____

_____

Mail CD / Fax Report to:

6060 N Central Expressway, STE 500

Dallas, TX 75206

Office 469-458-9800

Fax 469-458-9900