MTV IR
INTERVENTIONAL RADIOLOGY

Authorization / Consent for Patient Records

Patient Name : _____

Patient DOB : _____

Patient Address : _____

Patient Phone Number : _____

Patient Signature: _____

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

_____

Mail CD / Fax Report to:

MTV IR

6060 N Central Expwy, STE 500

Dallas, TX 75206

Office 469-458-9800

Fax 469-458-9900