ORIGIN MRI & DIAGNOSTICS

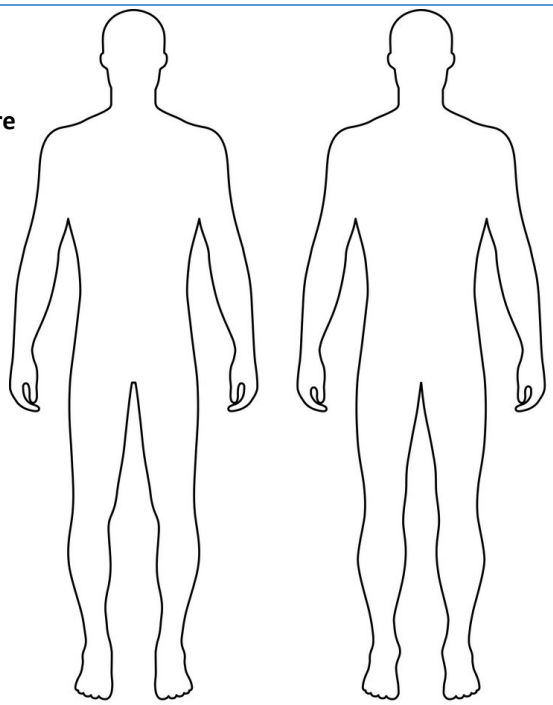
Phone: **(832) 982-0845**
Fax: **(888) 663-9778**

PATIENT INFORMATION			
Last Name:	**First Name:**	**Middle Name:**	
Date of Birth: **Age:**	**Sex:** ☐ **Male** ☐ **Female**	**Home Phone: ( ) -**	**Cell Phone: ( ) -**
Date of Injury:		**Physical Address:**	
SS#:		**City:** **State:**	**Zip Code:**
Occupation:		**Email Address:**	

REFERRING PROVIDER INFORMATION
Provider Name:
Phone: ( ) -
Fax: ( ) -

REASON WHY YOU ARE HERE
Please explain what the problem is:

Draw on figure where pain is located:



TREATMENT AUTHORIZATION

I voluntarily consent to the rendering of care and treatment as Origin MRI & Diagnostics providers and personnel, in their professional judgment, deem necessary for my health and well-being. My consent shall cover medical examinations and diagnostic testing (including MRI scan, CT scan, Xray) IV placement, IV and Oral contrast administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that Origin MRI & Diagnostics or its staff have not made any guarantee or promise as to the results that may be obtained.

Patient/ Guardian Name: _____

Patient/ Guardian Signature: _____ Date: _____

MEDICAL RECORDS AUTHORIZATION

I hereby authorize the release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize the release of findings to the provider named above for their records.

I hereby request that any medical records to be released to: Origin MRI and Diagnostics, 9135 Katy Freeway, Houston, TX 77024

Phone: (832) 982 - 0845 Fax: (888) 663 - 9778

Patient/ Guardian Name: _____

Patient/ Guardian Signature: _____ Date: _____