TRIUMPH RADIOLOGY

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MINOR CONSENT

MINOR NAME____ DOB____________________

RESPONSIBLE PARTY (GUARANTOR) FOR THIS MINOR PATIENT:

NAME____DOB____________________

RELATIONSHIP TO MINOR____

___________________________________ __________________ _____ ___________
ADDRESS (if different from the patient's) CITY STATE ZIP

_________________________ _____________________________
HOME PHONE CELL PHONE

By signing below, I give Triumph Radiology consent to perform exam as ordered.

____________________________________ _____________
Parent/Legal Guardian Signature Date