REGIONAL MEDICAL IMAGING

LEGAL REPRESENTATIVE PERMISSION FORM

Patient Name: _____ **Date of Birth**: _____

I, _____ , give permission to the physicians and medical
Legal Representative

Staff at Regional Medical Imaging, PC to consult, treat and perform any diagnostic testing on.

_____ , who will be accompanied by
Patient Name

_____ , who has brought the patient in on my behalf.
Alternative Representative

This permission for is good for:
□ The following date: _____
□ The following date range: _____ to _____
□ All dates (does not expire)

_____ _____
Signature of Legal Representative **Date**

_____
Relation of Legal Representative

_____
Address

_____
Phone

_____
Relation of Alternative Representative

Please fill out and send back to the office:
Fax: Genesee County - 810.732.1945 / Royal Oak – 248.399.7226 / Novi – 248.536.0420
Mail: 3346 Lennon Rd. Flint, MI 48507