CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize:

The Maternal Fetal Center
Danielle M. Esters, MD
1035 S. State Road 7, Suite 120 A
Wellington, Fl 33414
Tel: (561) 790-0472
Fax: (561) 793-3921

To release to:____

Address: ____

____

My medical history, laboratory results, pathology results, x-rays, and other material regarding the medical consultations and treatments which I have received. I acknowledge that the information to be released MAY INCLUDE materials regarding HIV (AIDS), DRUG, or ALCOHOL ABUSE, or MENTAL HEALTH ISSUES, which are protected by Federal Law. My signature below authorized release of all such information.

Patient Name (please print) ____________________________________

Date of Birth: ____

Social Security # ____

Patient Signature:____

Date: ____

Witness: ____