

# CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

To release to:    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

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: \_\_\_\_\_