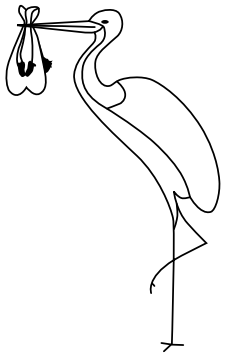
OBSTETRIX MEDICAL GROUP



RELEASE OF MEDICAL INFORMATION

I give my permission to Maternal Fetal Diagnostic Center to discuss my medical information/treatment with the person(s) listed below. (This disclosure is valid until we are given further notice.)

_____ Relationship _____

_____ Relationship _____

By signing this form, you acknowledge the Release of Medical Information disclosure.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Print Name of Patient | Print Name of Authorized Representative