



PRENATAL CARE VERIFICATION / PATIENT CONSENT

To: Belly View Ultrasound

_____ is currently a patient under Dr. _____ for her pregnancy. She has undergone a full diagnostic ultrasound during the second trimester of her pregnancy.

The results of the ultrasound were: _____ Normal _____ Abnormal

If abnormal, please explain briefly:

Belly View Ultrasound Services & Disclaimer

Using the latest in 3D/4D fetal imaging, Belly View Ultrasound allows your patients to view their baby during a relaxed and personalized ultrasound session. We offer a non-diagnostic ultrasound. We do not provide measurements, determination of due dates, or other related diagnostic information. Our services are NOT INTENDED AS A REPLACEMENT for a full diagnostic ultrasound. Our mission is to give parents a visual closeness and to strengthen their bond with their unborn child.

PROVIDER INFORMATION

Address: _____
City State/Zip
Phone _____ Fax _____
Print Name _____ Date _____ Signature _____ Date _____

Patient Consent to Release Information

I authorize the above named **Physician and his/her staff** to release the information above to Belly View Ultrasound. Furthermore, I authorize that this information may be provided to Belly View Ultrasound via Fax (956) 994-8448.

Thank you,

Print Name _____ Date _____ Signature _____ Date _____