AccuView IMAGING CENTER

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Portland, Maine 04103

(207) 797-9700
Fax: (207) 878-4135

PRENATAL CARE VERIFICATION

To: AccuView Imaging Center
RE: 4D Ultrasound

_____ is currently a patient under my care 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:

_____

_____

_____

_____

Patient Consent to Release information:

I authorize the above named physician and his/her staff to release the information above to AccuView Imaging Center in Portland, Maine. Further, I authorize that this information may be provided to AccuView via facsimile.

Thank you.

_____ _____
Print Date

_____
Signature

Provider Signature

Name: _____

Printed: _____

Date: _____