P.O. Box 789, Buffalo, WY 82834
Phone: 866.927.2524
Fax: 866.927.2523
hello@babyriddle.com
www.babyriddle.com

Authorization to Release Information

Patient hereby releases any and all claims Patient may have, now or in the future, known or unknown, against Baby Riddle, its officers, directors, agents and employees, and Patient's physician, ultrasound technician, doula, healthcare facility and any other healthcare provider, arising from or relating to an error in determination of the gender of Patient's baby. By signing below, you acknowledge that you understand the scope of this release and have had an opportunity to consult with counsel regarding the same, regardless of whether you have elected to do so.

Patient's Name: _____
(First) (Middle) (Last)

Due Date: _____ Email: _____

Address: _____

Phone: _____

Patient's Signature: _____ Date: _____

At my request, I voluntarily authorize _____
to release the gender of my child and due date of the patient listed above to:

Baby Riddle
P.O. Box 789
Buffalo, WY 82834
Phone: 866.927.2524
Fax: 866.927.2523

The gender of my child is a:

____ Boy

____Girl

This above said information is to be released and no other medical information from patient's records to Baby Riddle. The information is disclosed voluntarily to Baby Riddle, from patient. No information disclosed to Baby Riddle will be released to third parties.

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED