

PERMISSION FOR TREATMENT

Permission is hereby granted for the physicians, employees or agents of TAMPA OBSTETRICS/EXODUS WOMEN'S CENTER to provide the patient named below such medical and/or surgical treatment as is deemed necessary. By my signature, I also grant permission for the individual named below to be provided family planning care and/or counseling.

NAME _____ CHART # _____

SIGNATURE _____ DATE _____

PATIENT – PARENT – LEGAL GUARDIAN

* If Legal Guardian, relationship to patient _____ . Also, must provide proof of legal guardianship.