PHYSICIANS FOR WOMEN, P.C.
880 EASTPORT CENTRE DRIVE, SUITE 200
VALPARAISO, IN 46383

CONSENT TO TREAT MINOR
(17 YEARS OR YOUNGER)

I, ____, parent and/or legal guardian, consent to the care and treatment of

__________________________________ (patient) by Physicians For Women. This consent is for present and future medical care and treatment and will remain in full force and effect until revoked in writing by me or other parent/legal guardian.

_____________________________________ ___________________

Parent and/or Legal Guardian Date