CARE FOR WOMEN

The comprehensive care you need.
The compassion & convenience you deserve.

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Sharon K. Zavala, M.D.
Obstetrics & Gynecology

MINOR CONSENT FORM
FOR MEDICAL AND/OR SURGICAL TREATMENT

As the parent or legal guardian of _____
(minor's name)

I hereby authorize the physicians at Care for women to provide medical care, including, without limitations, routine diagnostic procedures and medical treatment, which is to include whatever procedures that are deemed necessary by the attending physician or other such physicians or assistants as may be designated by the physician for the care of my minor child for the period of time she is considered a minor.

The minor similarly requests and authorizes the Care for Women physicians to administer any medical care and/or treatment deemed necessary or advisable in their diagnosis and treatment.

It is understood that the practice of medicine and surgery is not an exact science, and acknowledged that no warranty, guarantee, or assurance has been made by Care for Women as to the results of treatments or examinations, nor may any such warranty, guarantee, or assurance be otherwise obtained.

DATE: _____

PARENT OR
LEGAL GUARDIAN'S SIGNATURE: _____ **Date:** _____

MINOR'S SIGNATURE: _____ **Date:** _____

WITNESS'S SIGNATURE: _____ **Date:** _____

CARE FOR WOMEN
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