



## *Consent to Treat*

Date:

Patient Name:

DOB:

I, \_\_\_\_\_, the parent/guardian of said minor,  
\_\_\_\_\_ give North Central Women's Health Partners  
permission to evaluate, diagnose and treat as medically necessary during today's visit.

If there are any questions or concerns please feel free to contact me at:

Phone # \_\_\_\_\_

Thank you,

\_\_\_\_\_  
Signature