ALL FEMCARE PROFESSIONALS
HUGO L. PEREZ, M.D.
JOSE L. CALDERON, M.D.

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by All Femcare OB GYN Center deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature:_____**Date**_____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and healthcare) with: ( ) Spouse ( ) Children ( ) Other_____

Please list the family members or significant others, if any, whom we may inform/discuss your medical condition and/or contact in case of emergency.

Name_____

Relationship_____Phone#_____

Name_____

Relationship_____Phone#_____

Name_____

Relationship_____Phone#_____

Name_____

Relationship_____Phone#_____

Messages may be left on my answering machine regarding my health & appointments made:

( ) YES ( ) NO

Signature:_____**Date**_____