ADVANCED OBSTETRICS & GYNECOLOGY., LLC
265 S. PARKSIDE DR. SUITE 100
COLORADO SPRINGS, CO 80910
(719) 633-8773 FAX: (719) 633-1905

CONSENT FORM TO TREAT MINORS

I (We) request and authorize ADVANCED GYNECOLOGY PROF, LLC and its personnel to deliver medical care to my child, listed below:

PLEASE PRINT
Patient Name: _____

Patient Date of Birth: _____

Please try to contact me (us) regarding health care for my child at the following phone number(s):
Parent(s)/Guardian(s) name(s): _____

Address: _____ Home Phone: _____
_____ Cell Phone: _____
_____ Work Phone:_____

Responsible Billing Parent/Guardian (if different from above)
Name(s): _____
Address: _____ Home Phone: _____
_____ Cell Phone: _____
_____ Work Phone: _____

Signature: _____ Date: _____