

GENESIS OB/GYN, INC

12266 DePaul Drive, Suite 200
Bridgeton, Missouri 63044
(314) 291-2975

CONSENT TO GYNECOLOGICAL, EXAMINATION AND TREATMENT

PATIENT: _____
 LAST FIRST DATE OF BIRTH

I request and authorize the doctors and/or nurse practitioners associated with Genesis Ob/Gyn, Inc. to perform a gynecological examination. I also authorize the above healthcare providers to order necessary test(s) and/or procedure needed for diagnosis.

I acknowledge that I have read this document in its entirety and that I fully understand its meaning and that all blank spaces have been completed prior to my signing.

If patient is unable to sign or is a minor, complete the following:

Patient is unable to sign because _____ or is a minor, _____ years of age.

Date: _____

Signature of Patient

WITNESS:

**IF CONSENTING PARTY IS
OTHER THAN PATIENT:**

I hereby attest that I am the person
legally authorized to provide
Consent for treatment to the above-
named patient.

Signature of Consenting Party