

Lake Pointe Women's Centre

Obstetrics and Gynecology

Consent to Release My Medical Information

I, _____ give the physicians and staff of Lake Pointe Women's Centre permission to discuss all aspects of my personal health history, condition and treatment with my:

You must select at least one and sign.

Patient Signature

Date

Witness Signature

Date

If patient is an minor or unable to sign:

Name of Person Giving Consent

Date

Signature

Date

Witness

Date