



Saint Louis
GYNECOLOGY & ONCOLOGY

CONSENT FORM

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I, _____, consent to medical treatment by Dr. Elbendary or his designee, for myself or for the patient for whom I am the parent or legally authorized representative. I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures or examinations.

Signature of Patient (or legal guardian/representative)

Date

Relationship to patient

Witness

Date