IVANA MD

Gynecology • Sexual Health • Intimacy Coaching

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to

Dr. _____, with ***IVANA MD PLLC***

Birth Date #_____

_____ _____

Date Patient/Legal Representative

Save Print Reset Form