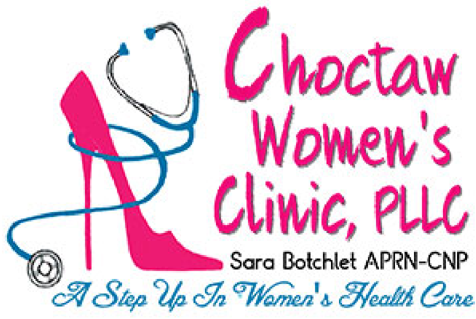

Legal Guardian Consent

Date: ____/____ /____

I, _________________________, legal guardian of _________________________, give permission to

Choctaw Women's Clinic to treat _________________________ in my absence.

Print Name: _____________________________________ Date of Birth: ____/____ /____

Signed: ____

Witness: ____