DR. GLENA J. DAVIS
OBSTETRICS/GYNECOLOGY
PATIENT CONSENT TO TREAT

I hereby give my consent to **Glena Davis, D.O**., and authorize her to provide my medical treatment. I understand that **Glena Davis, D.O**. will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize **Glena Davis, D.O**. to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name ______________________________________

Patient Signature ____________________________________ Date _______________

Parent or Legal Guardian Signature (for minor) ____________________________________

Relationship to the Patient ___________________________

Signature of Treating Provider ________________________ Date _______________

Note: Please have your legal counsel review this form before using it.