FOR WOMEN HEALTH CARE
Ayodele Olowookere, M.D., P.A.
Obstetrics & Gynecology

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment to For Women Healthcare. I understand and agree that the signatures on this form will not expire without written notice or in the case that a minor becomes an adult, and that a photocopy or scanned image of this form is considered valid as the original.

Patient or Legal Guardian Signature

Date

Ph. (432) 688-8888

2110 W. Michigan Ave.
Midland, TX 79701

(432) 789-1433

FOR WOMEN HEALTH CARE
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AUTHORIZATION FOR MEDICAL RECORDS

I hereby authorize Medical Records concerning:

Patient's Name _____

Current Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Social Security Number _____

To be released from:

Physicians Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Please send to:

Ayodele Olowookere, M.D., P.A.
Obstetrics & Gynecology
2110 W. Michigan Ave.
Midland, TX 79701 Phone (432) 688-8888 Fax (432) 78789-1433

I understand that disclosure will be made for and will be limited to the following specifici types of information for treatment rendered to me during the period from ____ to ____.

_____ Medical History & Physical _____ Operative Reports

_____ Lab & X-ray Reports _____ All Records

_____ Treatment & Progress Notes _____ (Other) Please List

_____

_____

_____

I understand that this consent is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon. If not revoked, it shall terminate 90 days from date signed without express revocation.

_____

Patient Name Signature Date

PLEASE FAX OR SEND AS SOON AS POSSIBLE. THANK YOU!