Total Woman Health Care, P.A.
Dr. Wendelly Vasquez, Dr. Amir H. Fazeli
885 Sedalia Street, Suite 100, Ocoee, FL 34761
PH 407-294-2994 FX 407-294-2882

PELVIC EXAMINATION CONSENT FORM

Patient Name: ________________________________ Date of Birth: ____/_____/_____

- CONSENT: I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examination being performed by my physician, medical student, or other health care practitioner.
- NATURE OF PELVIC EXAMINATIONS: It is the exam performed by our Gynecologist or health care provider that involves examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissues, or organ using any combination of modalities which may include, but not limited to, the health care providers gloved hand or instrumentation.
- VALIDITY OF CONSENT: The Patient, or the Patient's legally authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient's legally authorized person, dated this consent form below, unless otherwise revoked in writing by the Patient, or the Patient's legally authorized person

I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE

PATIENT SIGNATURE: ____________________________________ DATE: ______________

Legally Authorized Person Signature: ____

Relationship to Patient: _________________________________

Legally Authorized Person Printed Name: ____________________ DATE:___________

Witness Signature: ____________________________________

Witness Printed Names: ______________________________________ DATE: ______________