Patient Name: Date of Visit:
MRN:
DOB:

Consent for Treatment

1. I _____ (patient name) give permission for **Partners in Abortion Care** to give me medical treatment.

2. I understand that I must pay for any costs of treatment.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (for patients under 18) Date

Consent could not be obtained due to medical emergency. The nature of the emergency is:

_____

_____

_____ _____
Clinician Signature Date