Reproductive Health & Wellness Center

INFORMED CONSENT TO BE TREATED BY REPRODUCTIVE HEALTH AND WELLNESS CENTER

I hereby authorize Marcus Rosencrantz, MD, Reproductive Health and Wellness Center, and/or designated physicians/assistants, to provide me with medical care/be my physician(s). I understand that this is a general consent for medical evaluation/care/treatment and that additional consents may be required for more specific medical treatments and/or procedures.

Patient's Name	**Patient's Signature**	**Date**
Partner's Name	**Partner's Signature**	**Date**
RHWC staff	**RHWC Signature**	**Date**