DALE R MYERS MD, FACOG
Gynecology/Women's Health
1613 Stampede Ave, Suite A1
Cody, WY 82414
307/587-1155
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CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian of _____, minor, I hereby give my consent to Dale R Myers MD, and/or such assistants appointed by the doctor, to examine and treat medically as necessary.

_____ _____
Patient Signature Date

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date