

PATIENT CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct
[Print Patient's Name]

[Insert Name of Practice]

and my treating health care provider, the employed and/or contracted medical personnel of _____ [Insert Name of Practice] _____ as deemed necessary by my treating physician, and the medical students and/or students receiving training as a health care provider who may be involved in my care, to perform a pelvic examination, including vaginal sonography, as described above. I understand that a pelvic examination may be needed while receiving medical care from _____ [Insert Name of Practice] _____ in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with _____ [Insert Name of Practice] _____ unless I revoke this consent in writing by hand delivering a copy of the revocation to _____ [Insert Name of Practice] _____. By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

Patient/Legal Representative Signature

Printed Name and Date

Witness Signature

Printed Name and Date

Physician/Provider Signature

Printed Name and Date