

**Jeffrey P. Block M.D., F.A.C.O.G.**

A Professional Corporation  
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**CONSENT FOR MEDICAL TREATMENT**

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If not signed by the patient, please state your relationship and patient name.

Relationship: \_\_\_\_\_

Patient: \_\_\_\_\_

Date: \_\_\_\_\_