

**SUSSMAN OBGYN LLC**

**O1301 N Congress Ave Ste. 200 ♦ Boynton Beach, FL 33426 ♦ (561)742-3929 Fax (561)742-3931**

**O 7301-A W. Palmetto Park Rd. Suite# 200B ♦ Boca Raton, FL 33433 ♦(561) 394- 4473 Fax (561) 394- 5997**

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

Patient Name:\_\_\_\_\_ DOB:\_\_\_\_\_

I, \_\_\_\_\_, as parent or legal guardian of  
\_\_\_\_\_, Give my permission to the providers of  
Sussman Obgyn / TLC Womens health LLC to examine & give medical treatment to my child on the date  
of: \_\_\_\_\_.

I understand that my daughter may disclose to the doctor certain information pertinent to complete  
gynecological exam, which she may not want discussed with her parents or guardian, although the doctors  
encourage openness between parents, guardians and children, they will not reveal anything that she asks  
be held in confidence.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

**PLEASE SIGN THE SECOND PART: IF YOU WANT YOUR CHILD  
TO COME IN ANOTHER DAY WITHOUT YOU.**

I also give permission to the providers of Sussman Obgyn LLC / TLC Womens Health to examine and give  
medical treatment to \_\_\_\_\_ at any future dates.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

We will also require a photo ID