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*Obstetrics • Gynecology • Infertility*  
*Mammagraphy & Laser Surgery*  
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## DISCUSS CONSENT TO MEDICAL CARE AND TREATMENT

I, \_\_\_\_\_, the patient

authorize and consent to the sharing of any and all medical care and/or treatment by Winchester Womens Specialists, PC when, in the sole discretion of the attending physician, such care treatment and procedures are immediately necessary or advisable in the interest of myself and well-being, and is not advisable to take the time to contact me in advance.

\_\_\_\_\_  
Individual/Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
WWS Employee