

**Obstetrics & Gynecology Associates, P.A.**

specializing in  
*Obstetrics, Gynecology, Infertility*  
*and Laser Surgery*

Name:  
DOB:

Referred by:  
Date:

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I \_\_\_\_\_ GIVE OBSTETRICS AND  
GYNECOLOGY ASSOCIATES, P.A. PERMISSION TO CIRCUMCISE MY SON  
UPON DELIVERY. PAYMENT WAS PAID IN FULL ON  
\_\_\_\_\_. I AM AWARE THAT THIS PAYMENT COVERS THE  
PHYSICIAN'S SERVICES ONLY. I WILL RECEIVE AN ADDITIONAL  
CHARGE FROM THE HOSPITAL THAT WILL BE BILLED TO ME AT THE TIME  
OF SERVICE.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE