Reproductive Health Care Consent Form

Date: **[Insert Date]**

I, **[Patient's Name]**, hereby give my consent to receive reproductive health care services as outlined below:

Services Included:

- Contraceptive Counseling
- STD Testing and Treatment
- Pregnancy Testing
- Prenatal Care
- Educational Resources

I understand that:

- The services provided may involve risks and benefits which have been explained to me.
- I have had the opportunity to ask questions and discuss my concerns regarding the procedures.
- I may withdraw my consent at any time without affecting my right to future care.

By signing this form, I acknowledge that I have read and understood the information provided above.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____