Plastic Surgery Center of PA

410 Cranberry Street Unit 310
Erie, PA 16507

Gunnar E.O. Bergqvist, M.D.

Date: _____

I authorize Gunnar Bergqvist, M.D. to examine and treat

_____
(print name)

I also hereby authorize the members of Dr. Bergqvist's office staff to assist with my care.

Signature: _____

Witness: _____