Pediatric Associates of Mt. Carmel, Inc.

Established 1972

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Treatment Authorization

Name of Patient _____ DOB _____

Name of Patient _____ DOB _____

Name of Patient _____ DOB _____

Name of Patient _____ DOB _____

I hereby authorize:

_____

To present my child and/or children to Pediatric Associates of Mt. Carmel, Inc. for medical care in my absence, and give Pediatric Associates of Mt. Carmel, Inc. permission to treat any and all medical conditions during this and subsequent visits. This consent is good for one year starting _____ and ending _____.

This form must be updated annually.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Relationship to Patient

Batavia
2055 Hospital Drive
Suite #250
Batavia, Ohio 45103

Eastgate
4371 Ferguson Drive
Cincinnati, Ohio 45245
(513) 752-3650
(513) 752-3387 Fax

Loveland
10572 Loveland Madeira Rd.
Loveland, Ohio 45140