Authorization for Treatment of Minors

I, _____, give my permission for the following adult(s):
Print Name (Parent or Legal Guardian)

_____ _____
Name Relationship to child(ren)

_____ _____
Name Relationship to child(ren)

_____ _____
Name Relationship to child(ren)

to bring my child(ren):

_____ _____
Name DOB

_____ _____
Name DOB

_____ _____
Name DOB

to **Northeast Cincinnati Pediatric Associates, Inc.** for the purpose of medical examination and/or treatment and to consent to and authorize such examination and treatment without having to contact me.

This authorization shall automatically expire one (1) year following the date last written below.

Signed: _____ _____
Name of Parent or Legal Guardian Print Name of Parent or Legal Guardian

Date: _____

Signed: _____ _____
Name of Witness Print Name of Witness

Date: _____