Liberty Sharonville Pediatrics, Inc.
513-563-0044

11258 Lebanon Road
Cincinnati, Ohio 45241

7097 Liberty Centre Drive
West Chester, Ohio 45069

CONSENT TO TREATMENT
(Minor / Adult Children)

I_____, do hereby consent and authorize the physicians,
(Please print full name)
and/ or such assistants or designees of Liberty Sharonville Pediatrics, Inc. to treat my children listed below in my absence. Liberty Sharonville Pediatrics, Inc. may provide all services they deem medically necessary to secure the good health of my children this is to include such services as examinations, immunizations, laboratory, etc..

Children Covered By This Agreement
Please list full names and Dates of Birth

_____ _____ _____

_____ _____ _____

_____ _____ _____

The following person/s has my permission to seek care and accompany my child/children to Liberty Sharonville Pediatric's, Inc.

_____ Relationship to patient _____

_____ Relationship to patient _____

_____ Relationship to patient _____

I affirm that I have the legal right to consent to this.

This consent is binding until specifically revoked by myself or another person who has the right to sign or revoke this form. I also accept financial responsibility for the treatment given to my children in my abcense.

_____ _____
Signature of Legal Guardian **Date**

_____ _____
Signature of Witness **Date**