Cincinnati Children's
changing the outcome together

PERMISSION TO AUTHORIZE CONSENT FOR TREATMENT

I am the parent/legal guardian of the following named child/ward_____, whose date of birth is _____. I have the legal right to consent to medical and surgical treatment for this child/ward. I hereby authorize the following individual, _____, whose relationship to this child/ward is _____, to give legal informed consent to any and all medical/surgical/dental care, treatment and/or attention for this child/ward which is deemed necessary and appropriate by a healthcare provider licensed in the state in which the care and treatment is to be provided.

I further agree to reimburse the healthcare provider for the cost of rendering services which are not covered by insurance or health plan. The child is covered under the following health plan:

_____

I can be reached at the following address and telephone number: _____

_____

The following information is important for the medical/surgical/dental care of my child/ward:

Allergies:_____

Current medications:_____

Significant medical/surgical/dental history: _____

_____

_____

_____

Pediatrician/Primary Care Provider & phone number:_____

Dentist & phone number: _____

Authorization to consent expires: _____
(Expires one year from date of signature unless otherwise indicated)

_____ _____
Parent/Legal Guardian Signature Time/Date

I am the ☐ Parent ☐ Legal Guardian.

_____
Printed Name of Parent/Legal Guardian

_____ _____
Witness/Notary Signature Time/Date

_____
Printed Name of Witness/Notary

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