

Pediatric Associates of Mount Carmel, Inc.

Thomas J. Forristal, M.D., Emeritus
Robert J. Carson, M.D., Emeritus
Emanuel O. Doyne, M.D.

Helene P. Blitzer, M.D.
Cathrine L. Yost, M.D.
Daniel R. Kroeger, M.D.
Lynn K. Peters, D.O.

Jennifer B. Richard, M.D.
Christopher B. Peltier, M.D.
Michael S. Chamberlin, M.D.

TREATMENT AUTHORIZATION FORM

Name of Patient _____ DOB _____

I hereby authorize _____ to present my child to Pediatric Associates of Mt. Carmel for medical care in my absence, and give Pediatric Associates of Mt. Carmel permission to treat any and all medical conditions during this and subsequent visits. This consent is good from _____ to _____.
(not to exceed one year)

Signature _____ date _____

Relationship to Patient: _____

Batavia
2055 Hospital Drive
Suite #250
Batavia, OH 45103

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

Loveland
10572 Loveland Madeira Rd.
Loveland, Ohio 45150