OLENTANGY PEDIATRICS, INC
MEDICAL TREATMENT CONSENT FORM

General Consent for Treatment

By signing below I am acknowledging that I am the patient or parent/legal guardian if a minor child. I voluntarily authorize and consent to medical care, treatments, diagnostic tests, and psychological services that the providers of Olentangy Pediatrics, Inc. and their designated associates or assistants believe are medically necessary.

I understand that by signing this form that I am giving permission to the doctors, nurses, physician assistants, and other healthcare providers in this medical office to provide treatment as long as a physician/patient relationship exists. I understand I have the right to revoke this authorization in writing at any time.

By signing, I confirm that I have legal ability to consent for treatment of services provided by Olentangy Pediatrics, Inc.

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Patient Name DOB

______________________________________ ____________________
Patient Name DOB

______________________________________ ____________________
Patient Name DOB

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Patient Name DOB

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Patient Signature or Parent/Legal Guardian if patient is under 18 Date

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Parent or Legal Guardian Name Printed, if patient is under 18