UNION PEDIATRICS
8667 US HWY 42, SUITE 300
UNION, KY 41091

AUTHORIZATION TO TREAT MINORS
Consent Form

I have the legal right to authorize this facility to deliver medical treatment to my child/children listed below.

Patient Name	Date of Birth
1. _____	___/___/____
2. _____	___/___/____
3. _____	___/___/____
4. _____	___/___/____
5. _____	___/___/____
6. _____	___/___/____

List any LIMITATIONS to the medical care to be given to your child/children by Union Pediatrics. If no limitations, please state “NONE”.

_____

_____

Identify any limitations to the TIME FRAME for which this Authorization to Treat is given. If none, please state “NONE”.

_____

_____

X _____ _____

Parent/Legal Guardian Signature Date