Bethesda
Family Practice Residency
1775 Lexington Ave Suite 100
Cincinnati, Ohio 45212
Phone (513) 977-6700
Fax (513) 531-2624

(PLEASE PRINT)
PATIENT LAST NAME: _____ DATE: _____
PATIENT FIRST NAME: _____ DOB: _____

Involvement In Care: Parental Consent

Please list any and all persons whom you give permission to bring your child to appointments at our office. Please also include yourself on this form. If not listed, they will not be permitted to bring the child to the office for any appointments.

First Name _____ Last Name _____

Relationship _____ Phone # _____

First Name _____ Last Name _____

Relationship _____ Phone # _____

First Name _____ Last Name _____

Relationship _____ Phone # _____

First Name _____ Last Name _____

Relationship _____ Phone # _____

By signing this form you are acknowledging that the above listed person(s) have permission to accompany your child to appointments at our office. If any of this information changes, you are responsible for notifying us, preferably in writing.

Name of person completing this form (Please PRINT): _____

Relationship to patient: _____

Signature _____ Date _____