



LISA LARKIN, M.D.  
& ASSOCIATES

Patient. Focused. Personalized. Medicine.

### Authorization for Consent to Treatment of a Minor

Parent or legal guardian of:

\_\_\_\_\_  
Name of Minor (Last, first, middle)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security #

I consent to the physicians and physician assistant of Lisa Larkin M.D. & Associates providing medical care and treatment, including minor gynecologic procedures and diagnostic services, for my child. I understand that if any invasive or serious procedures are needed, I would be contacted in advance of the procedure or service, unless it is an emergency. **Failure to have consent on file except in emergency situations may delay treatment, while we attempt to obtain consent.**

This consent expires upon the patient's 18<sup>th</sup> birthday, unless revoked in writing prior.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

Contact Information Parent/Guardian:

\_\_\_\_\_  
(Home Number)

\_\_\_\_\_  
(Work Number)

\_\_\_\_\_  
(Mobile Number)

Please return this form at the time of patient's next visit, or mail or fax to the office at:

Lisa Larkin M.D. & Associates  
4460 Red Band Expressway Ste. 100  
Cincinnati, OH 45227

Fax number: (513) 272-7084