MEDICAL CONSENT AUTHORIZATION FOR MINORS

_____ I, _____, am the parent of the child listed below and there are no court orders now in effect that would keep me from having the power to give another person permission to bring in and consent to care for my child.

_____I, _____, am the legal guardian or legal custodian of the child by court order (copy attached) and there are no other court orders in effect that would keep me from having the power to give another person permission to bring in and consent to care for my child:

_____ DOB: _____

Adults that are granted permission to consent to examinations and treatment and granted permission to receive health information about my child:

NAME: _____ RELATIONSHIP: _____

The person named above may consent to the following examination and treatment for my child and may have access to any and all records, including, but not limited to, insurance records regarding any such services. I confer the power of consent freely and knowingly in order to provide for the child and not as the result of pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification to my child's medical and insurance providers, and the person(s) named above.

In witness of, I have signed my name to this medical consent authorization, on this _____ day of _____ 201_ in _____, Pennsylvania.

Printed Name Parent/Guardian _____

Parent/Guardian Signature _____

Witness Printed Name _____

Witness Signature _____