WASHINGTON HEALTH SYSTEM

Medical Consent Authorization for Treatment of a Minor

I, _____ (name), am the Parent/Legal Guardian (if Legal Guardian, attach copy of court order) of the child(ren) listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

I, _____, do hereby confer upon
(Name of Parent/ Legal Guardian)

_____
(Name of Person Bringing Child(ren) for Care and Relationship to Child(ren)

Residing at: _____, the power to consent to necessary medical or mental health examination and/or treatment at WHS – Washington Pediatrics (as identified below) for the following child(ren):

1. Name: _____ Born on: _____

Residing at: _____

2. Name: _____ Born on: _____

Residing at: _____

3. Name: _____ Born on: _____

Residing at: _____

And on the child(ren)'s behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity.

The power that I confer is specifically limited to health care and mental health care decision making, and it may be exercised only by the person named above.

The person named above may consent to the child(ren)'s examination and/or treatment as follows (check all that do apply):

Medical _____ Dental _____ Surgical _____ Developmental _____

Mental health _____ Immunizations _____

Other (describe): _____

and may have access to any and all records, including, but not limited to, insurance records regarding any such services.

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I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats or payments by any person or agency.

This authorization (check one):

_____ is effective only on ____/_____/20___

_____ is effective from ____/_____/20___ to _____/_____/20___

_____ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time, by writing to

_____.
(name of practice)

In witness hereof, I have signed my name to this Medical Consent Authorization for Treatment of a Minor, on this ____ day of _____. 20__ in _____, Pennsylvania.

_____
Printed name of Parent or Legal Guardian

_____
Signature of Parent or Legal Guardian Date/Time

_____
Witness Signature Date/Time

_____
Printed Name and Address of Witness #1

_____
Witness Signature Date/Time

_____
Printed Name and Address of Witness #2

_____
Printed Name of Adult Person being given Power to Consent

_____
Signature of Adult Person being given Power to Consent Date/Time