MEDICAL CONSENT AUTHORIZATION (Act 52 of 1999 Medical Consent Act)

IF NEEDED FOR MULTIPLE CHILDREN, PLEASE COMPLETE ONE FORM PER CHILD.

FATHER: _____ D.O.B._____,
currently residing at _____
□ or no father is identified for my child, nor appears on my child's birth certificate;

MOTHER: _____ D.O.B. _____,
currently residing at _____;

The □ Father or □ Mother listed above is not participating in this Designation and Authorization and does not sign below for the following reason(s):
□ The parent is deceased, having died on _____ in _____.
□ The parent's whereabouts are unknown, with no communication since _____.
□ There exists an Order of sole legal and physical custody in favor of the signing parent from the Court in _____ dated _____. (Copy attached.)
□ The parent is mentally or physically unable to consent due to the following condition:
_____;
I/We_____,
(Name of Parents or Legal Guardians or Custodian)
do hereby confer upon
_____ D.O.B._____
(Name of Person Bringing Child for Care)

residing at_____
the power to consent to necessary medical or mental health treatment for the following child:
Name: _____ Born on: _____
Residing at:
_____
and on the child'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, including both, routine and emergency treatment and it may be exercised only by the person listed above.

The person named above may consent to the following examinations and treatment for my child. (Check all that apply):

o Medical o Surgical o Mental Health
o Immunizations o Development o Dental

o Other: _____

and may access any and all records, including, but not limited to, insurance records regarding such services. We are aware of our HIPPA rights and this consent shall be deemed to satisfy all HIPPA laws as we are not available to sign any additional consents.

I confer the power to consent freely and knowingly in order to provide for the child and not as a result of pressure, threats, or payments by any person or agency. This document (which consists of two pages) shall remain in effect until it is revoked by my written notification to my Child's medical, mental health care, and insurance providers, and the person named above.

TRANSLATION AND LANGUAGE: A translation of this Consent is attached for the benefit

of the parties. The English version shall control for purposes of interpretation or enforcement.

HEREBY GIVING CONSENT AND ACCEPTING AUTHORITY:

In witness whereof, I have signed my name to this medical consent authorization, on this _____ day of _____, 20_____ in _____, Pennsylvania.

_____

(Printed Name) of Parent or Legal Guardian

_____

(Signature) of Parent or Legal Guardian

_____

(Witness Signature)

_____

(Witness No. 1 Printed Name and Address)

_____

(Witness Signature)

_____

(Witness No. 2 Printed Name and Address)

_____

(Signature of Adult Person who is Being Given Power to Consent

Date of Signatures & Consent: Month _____ Day _____ Year _____

NOTARY VERIFYING IDENTIFICATION FOR ALL SIGNING INDIVIDUALS