St Luke's PHYSICIAN GROUP

MINOR CONSENT AUTHORIZATION FORM

If anyone other than a custodial parent will **ever** accompany this child to an appointment, this form **must** be completed and **in the patient's medical record** or the child will **not** be seen. This includes dropping the child off for an appointment or picking the child up after an appointment.

Please complete the appropriate section as it applies to your relationship with the child.

( ) I,_____, am the parent of the child listed below and there are no restrictions that would prohibit me from conferring the power to consent upon another person.

OR

( ) I,_____, am the legal guardian or legal custodian of the child listed below by court order (copy of attached court order required) and there are no restrictions that would prohibit me from conferring the power to consent upon another person.

Please provide the information requested below.

I,_____, do hereby confer upon,_____,

residing at:_____, the power to consent to necessary medical or mental health treatment for the following child:_____,

residing at:_____, and born on:_____, and on the child's behalf, do hereby state that the power to consent which I confer shall not be affected by my subsequent disability or incapacity.

The power which 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's (cross out all that DO NOT apply): medical, dental, surgical, developmental and/or mental health examination or treatment and may have access to any and all records, including but not limited to, insurance records regarding any such services.

I confer the power to consent freely and knowingly in order to provide for the child. This document shall remain in effect until it is revoked by notifying my child's medical mental health care, and insurance providers, in writing, and the person named above that I wish to revoke it.

I witness whereof, I,_____, have signed my name to this medical consent authorization, consisting of_____one____page, on this_____day of_____, 20_____, in

_____, Pennsylvania.

_____ _____

Printed Name Signature

Witness No. 1: Printed Name and Address: _____

Witness No. 1: Signature: _____

Witness No. 2: Printed name and Address: _____

Witness No. 2: Signature: _____