PATIENT LABEL AREA

MINOR CONSENT AUTHORIZATION FORM – NJ

We, ____ the Parents/Legal Guardians (if Legal Guardian attach copy of court order, if available) of the child(ren) listed below and there are no court orders in effect that would prohibit us from conferring the power to consent upon another person.

We, ____, do hereby confer upon, ____,
Print Names of Parents/Legal Guardians — Print Name of Person Authorized

residing at ____, the power to consent to necessary medical or mental treatment for the following child(ren):

Name: ____ Date of Birth: ____________________
Residing at: ____

Name: ____ Date of Birth: ____________________
Residing at: ____

Name: ____ Date of Birth: ____________________
Residing at: ____

and on the child(ren)'s behalf do hereby state that the power to consent which we confer shall not be affected by our subsequent disability or incapacity.

The power which we confer is specifically limited to health care and mental health care decision making and it may be exercised only by the person named above. This power shall expire upon the earlier of (1) 6 months from the execution date below or (2) _________ (if less than 6 months).

The person named above may consent to the following examinations and treatment for our child(ren) (check all that apply):
☐ Medical ☐ Dental ☐ Surgical ☐ Developmental and/or Mental Health (*excluding psychotherapy notes*)
☐ Immunizations ☐ Other ____

and may have access to any and all records, including, but not limited to, insurance records regarding any such services as needed to make treatment and payment decisions. This power shall not include consenting to marriage or adoption.

We 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 document shall remain in effect until it is revoked by a written notification signed by us to our child(ren)'s medical, mental health care, and insurance providers, and the person named above.

In witness whereof, we have signed our names to this medical consent authorization, consisting of ________ pages, on this _________ day

of _____________________, 20_______ in _________________, New Jersey.

____ ____
Printed Name of Parents or Legal Guardians — Signature of Parents or Legal Guardians

Witness No 1: Print Name and Address: ____

Witness No 1: Signature: ____

Witness No 2: Print Name and Address: ____

Witness No 2: Signature: ____

____
Signature of Adult Person Who is Being Given Power to Consent