Patient Name: _____
Identification Number:_____

UPMC LIFE CHANGING MEDICINE

Medical Consent Authorization
Act 52 of 1999 Medical Consent Act

I, _____, 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 or Legal Guardian or Custodian)

_____
(Name of PersonBringing Child(ren) for Care)

Residing at: _____
The power to consent to necessary medical or mental health treatment 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 following examinations and treatment for my child(ren) (check all that apply):

☐ Medical ☐ Surgical ☐ Mental Health

Patient Name: _____
Identification Number:_____

UPMC LIFE CHANGING MEDICINE

Medical Consent Authorization
Act 52 of 1999 Medical Consent Act

☐ Immunizations ☐ Development ☐ Dental

☐ Other (specify) _____
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 or the child(ren) and not as a result of pressure, threats or payments byany person or agency. This document shall remain in effect until it is revoked by my written notification to my child(ren)'s medical, mental health care, and insurance providers, and the person named above.

In witness hereof, 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

_____
Printed Name and Address of Witness #1

_____
Witness Signature

_____
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

Patient Name: _____

Identification Number:_____

UPMC LIFE CHANGING MEDICINE

Medical Consent Authorization

Act 52 of 1999 Medical Consent Act

INTERPRETER'S STATEMENT

Execute if an interpreter is provided to assist the individual in understanding this informed consent form:

I have translated the information and advice presented orally to the individual to be treated by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____

Cyracom ID (if applicable)

_____

Print Name

_____

Signature (Not required if a Cyracom Interpreter Was Used)