Einstein
HEALTHCARE NETWORK

Medical Consent Authorization

( ) I am the parent of the child(ren) listed below and there are no court orders now in effect that would prevent me from delegating the power to consent upon another person.

( ) I am the legal guardian or legal custodian of the child(ren) by court order (copy attached, if available) and there are no other court orders in effect that would prevent me from delegating the power to consent upon another person.

I, (name of parent/guardian) ________________________, do delegate the following person,

____

The power to consent to necessary medical or mental health treatment for the following child (ren):

Name: ____________________________ DOB: ______________________________

Name: ____________________________ DOB: ______________________________

Name: ____________________________ DOB: ______________________________

Name: ____________________________ DOB: ______________________________

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

This document shall remain in effect until it is revoked by notifying my child(ren)'s medical, mental health care providers in writing, and the person named above that I wish to revoke it.

In witness herein, ____________________________________, have signed my name to this

Medical consent authorization, on this __________ day of ____________________________.

______________________________ ______________________________
(Parent/guardian printed name) (Parent/gurardian signature)

______________________________ ______________________________
(Witness #1 printed name) (Witness #1 signature)

______________________________ ______________________________
(Witness #2 printed name) (Witness #2 signature)

THIS FORM IS EFFECTIVE UNTIL REVOKED; HOWEVER, IT IS RECOMMENDED THAT THIS BE REVIEWED ANNUALLY.