wesley
Health Centers
JWCH INSTITUTE

PATIENT NAME: _____

DOB: _____

PN#: _____

MEDICAL CONSENT AUTHORIZATION FOR PEDIATRICS

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 give the following individuals the power to consent.
(**Name of Parent or Legal Guardian)**

1ST PARENT

First Name	Last Name	Signature	Relationship

2ND PARENT

First Name	Last Name	Signature	Relationship

Please list any members who may bring child(ren) for medical care and the name of any other Parent, Legal Guardian, or Person that Wesley Health is permitted to receive medical information about the Child and/or is authorized to make medical decisions for the Child.

AUTHORIZED INDIVIDUALS (OTHER THAN LEGAL PARENT/GUARDIAN)
Valid Photo I.D. is required to be presented upon arrival

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Residing At:_____ **City:**_____ **State:**_____ **Zip:**_____

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On the child(ren)'s behalf, I 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 decision making, and it may be exercised only by the person(s) named above. The person named above may consent to the following examinations and treatment for my child(ren) (check all that apply):

□ **MEDICAL** □ **IMMUNIZATION** □ **DENTAL** □**OTHER:** _____

The person named above may have access to any and all records including but not limited to insurance records regarding any such services. ***(Please note that for medical record requests a medical authorization must be submitted and signed by the parent/legal guardian).***

I 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 (which consists of two pages) shall remain in effect until it is revoked by my written notification to my child(ren)'s medical mental health care and the person named above.

IMPORTANT RIGHTS AND OTHER STATEMENTS
RELEASE OF INFORMATION TO PARENT/LEGAL GUARDIAN – CONDITIONS AND EXCEPTIONS: If Wesley Health is contacted by a Parent or Legal Guardian of a Pediatric Patient requesting information relevant to their Child, upon reasonable proof of relationship, Wesley Health will release medical treatment related to the Child to the Parent/Legal Guardian and/or permit that Parent/Legal Guardian to approve medical treatment unless: a Court Order has previously been provided to Wesley Health Centers which (1) prohibits the Parent/Legal Guardian from receiving information and/or (2) prohibits the Parent/Legal Guardian from making medical decisions for the Child. If a Parent/Legal Guardian of the Child is not authorized to receive or authorize medical treatment, YOU understand it is YOUR obligation to provide Wesley Health Center the appropriate Court Orders limiting the Parent/Legal Guardian's rights as soon as possible so that it can held by Wesley Health Center with the Child's files.
Government Requests: Please take notice that Wesley Health Centers will release records to any governmental agency that issues a formal request for records in writing as part of a criminal or safety investigation.
This form, permitting the release of information to other designated person, does not need to be signed and completed in order to obtain enrollment, eligibility, or medical services from the Wesley Health Centers.
You do not have to agree to authorize any use or disclosure to persons Wesley Health is not otherwise obligated to release information by law or policy. If you revoke a completed authorization, it will not apply to information that has already been used or disclosed.
You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time.

EXPIRATION DATE	
This authorization shall expire **1 year** from the date of signature below unless revoked prior to that date.	
Print Name (*Legal Guardian*): **Signature :**	**Today's Date:** **Expiration Date:**
Staff Name: Staff **Signature :**	**Today's Date:**