PARKLAND FAMILY HEALTH CENTER
4520 PARK VIEW DR
SCHNECKSVILLE, PA 18078

I, _____am the parent/legal guardian of the following children and there are no other court orders now in effect that would prohibit me from conferring the power consent upon another person.

1._____

2. _____

3. _____

I do hereby confer the power of consent to necessary medical or mental health information to my children listed above to the following individuals.

NAME	**RELATIONSHIP**
_____	_____
_____	_____

The power that I consent is specifically limited to health care and mental health care decision making and may be exercised only by the person(s) named above. The person(s) named above may consent to the following examination and treatment for my children and may have access to any and all records, including but not limited to, insurance records regarding any such services:

- Medical
- Dental
- Surgical
- Developmental
- Mental Health
- Other _____

I confer the power to consent freely and knowingly in order to provide for the children 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 my written notification to my children's medical, mental health care and insurance providers and the person named above.

This authorization is signed by:_____

DATE:_____

Witnessed by:_____

DATE: _____