Children's Hospital of Pittsburgh of UPMC

Dermatology and Acne Treatment Center

Wexford Office
Pine Center, Suite 108
11279 Perry Highway
Wexford, PA 15090
Ph: 724-933-9190
Fx: 724-933-9194

South Fayette Office
Children's South
205 Millers Run Road, 3rd Floor
Bridgeville, PA 15017
Ph: 724-933-9190
Fx: 724-933-9194

Monroeville Office
Children's East
Building 1, Suite 110
4055 Monroeville Boulevard
Monroeville, PA 15146
Ph: 724-933-9190
Fx: 724-933-9194

www.chp.edu/CHP/dermatology

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Amy Lowe, PA-C
Lauren Mytrysak, PA-C
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Parent/Legal Guardian:

Thank you for choosing Children's dermatology and Acne Treatment Center for your child's care. We strive to achieve the highest level of satisfaction in providing accurate and efficient care to you and your family.

We are more than happy to see your child in your absence, but for legal compliance, we do need the attached form with parent/legal guardian signature and whom you are giving consent on your behalf for the office visit or any future visits to our office.

You can either mail this form back to our office at the above address or send it with your designated power of consent representative to the next appointment. We must have this completed form on file for your child's future appointments with the adult whom you have consented.

If you have any questions or comments please do not hesitate to contact our office.

Sincerely,

Douglas Kress MD/Robin Gehris MD

Children's Hospital of Pittsburgh

Medical Consent Authorization

Act 52 of 1999 Medical Consent Act

Form 3008 (7/05)

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 Person Bringing 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
☐ 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 (except as my be excluded under state and federal law.)

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 insurance providers, and the person named above.

In witness whereof, 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)

_____

(Witness No. 1 Printed Name and Address)

_____

(Witness Signature)

_____

(Witness No. 2 Printed Name and Address)

_____

(Signature of Adult Person who is Being Given Power to Consent)