

Patient name			
MHN	DOB	Age	Gender

Treatment of Minors – Limited (One Time Use)**Consent**

To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) accompany any minor children (17 years old or younger) to their medical/dental/mental health appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical/dental/mental health treatment appointment, the parent or legal guardian must sign this Consent – Treatment of Minors – Limited (One Time Use) form.

Parent or legal guardian name _____

Patient name _____

Appointee (person authorized to consent) _____ Relationship to child _____

I consent to care and treatment for my child related to his/her medical/dental/mental health treatment appointment at Marshfield Clinic Health System and affiliates:

on (date – month/day/year) ____ / ____ / ____

for (reason for appointment – specify approved care/procedures/tests/immunizations) _____

with (health care provider name) _____

My mature child, age ____ (not less than 16) can attend this medical/dental/mental health treatment appointment alone.

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers:

Home (_____) _____ – _____ Work (_____) _____ – _____

Cell (_____) _____ – _____ Other (_____) _____ – _____

I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services.

Child's parent/legal guardian signature _____

Relationship to patient _____

Print child's parent/legal guardian name _____

Signature date /_____/_____/_____
(month/day/year)

Child's parent/legal guardian address _____

Child's parent/legal guardian phone number _____

Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consent@marshfieldclinic.org