Patient name			
MHN	DOB	Age	Gender

Treatment of Minors in Parent/Legal Guardian Absence

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) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

☐ I/We *(parent's/legal guardian's name)* _____ authorize:

Appointee *(person authorized to consent)* _____

Relationship to patient _____ Appointee's phone number _____

Appointee's address _____

to consent to – check (✓) all that apply:

☐ Emergent or urgent care(including mental health treatment) at any of the following facilities when I cannot be reached: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations.

☐ Medical treatment, mental health treatment or dental care – including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) – at any of the following facilities: Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations

☐ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

for my child *(patient's name)* _____

during the period *(not to exceed maximum of 1 year)*:

☐ Date *(month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ For a maximum period of 1 year

☐ I/We *(parent's/legal guardian's name)* _____ authorize my driving-age child *(patient's name)* _____ to receive routine care, unaccompanied during the period *(date – month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ I/We *(parent's/legal guardian's name)* _____ authorize my child *(patient's name)* _____ to attend physical/occupational therapy appointments unaccompanied during the period *(date – month/day/year)* _____ /_____ /_____ to _____ /_____ /_____

☐ Providers at Marshfield Clinic, Inc., Family Health Center of Marshfield, Inc., Lakeview Medical Center, Inc. of Rice Lake, all Marshfield Medical Center locations, and all facilities owned and/or operated by the aforementioned organizations should try to contact me before providing care using the following numbers:

Home phone _____ Work phone _____ Cell phone _____

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

_____ _____

Child's parent/legal guardian signature | Relationship to patient

_____ _____ _____ /_____ /_____

Child's parent/legal guardian address | Parent/Legal guardian phone number | Signature date (m/d/y)

Send completed form to: Release of Information, Marshfield Clinic Health System, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

