

Patient name			
MHN	DOB	Age	Gender

**Treatment of Minor/Adult Ward in Parent/Legal Guardian Absence**

**Consent Revocation**

Patient address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home telephone number \_\_\_\_\_

I hereby revoke the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) generated by me on

(date: month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to:

Appointee name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**I understand that this revocation of the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) will not be valid if Marshfield Clinic Health System has already used or allowed for the consenting of care in reliance upon my authorization.**

\_\_\_\_\_  
Patient signature (Person authorized to consent for patient)      (Relationship to patient)      \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature date (m/d/y)

**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**