

Patient name			
MHN	DOB	Age	Gender

Treatment of Adult Ward in Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic Health System requires that a legal guardian (guardian appointed by a court) consent to the care of their court appointed ward, including mental health treatment. In the event that a legal guardian is unable to consent to the care, the legal guardian may delegate the right to consent to another adult. In the event that the ward presents for a non-urgent medical appointment without a legal guardian or a signed consent, treatment may be denied.

I/We (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 Marshfield Clinic Health System and affiliates
- 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 Marshfield Clinic Health System and affiliates

for my ward (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 (legal guardian's name) _____ authorize my ward
 (patient's name) _____ to receive routine care, unaccompanied during the period
 (date – month/day/year) ____ / ____ / ____ to ____ / ____ / ____ (not to exceed maximum of 1 year).
 Patient may receive care but cannot sign consent for treatment. All consents must be signed by legal guardian.

Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:
 Home phone _____ Work phone _____ Cell phone _____

I understand that my ward will be responsible for the cost of services rendered to the extent that my ward's insurance does not pay for these services.

Legal guardian signature _____ Signature date (month/day/year) ____/____/____

Legal guardian address _____ Legal guardian phone number _____

If additional guardian, legal guardian signature _____ Signature date (month/day/year) ____/____/____

Legal guardian address _____ 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