Marshfield Clinic Health System

Patient Name:	MHN:	DOB:	Sex:

Consent Treatment of Minors in Parent/Legal Guardian Absence

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 Marshfield Clinic Health System and affiliates when I cannot be reached

❑ 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

❑ 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 Health System and affiliates 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 and Date & Time Relationship to patient

_____ _____

Child's parent/legal guardian address 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.consents@marshfieldclinic.org

  See next page for Telephone Consent documentation. Additional copy to patient

Patient Name:	MHN:	DOB:	Sex:

☐ **Telephone consent** ***(or verbal consent to include those physically unable to sign)***

Today's date (month/day/year) / / Time _____ Telephone - -

Name of person authorizing _____ Relationship _____

Reason for telephone consent _____

❑ Person authorized treatment/procedure ❑ Person **DID NOT** authorize treatment/procedure

_____ _____
Witness signature and date & time PRINT witness name

_____ _____
Second witness signature and date & time PRINT witness name

