Patient name			
MHN	DOB	Age	Gender

Treatment of Adult Ward in Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic/Family Health Center 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 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 at Marshfield Clinic/Family Health Center when I cannot be reached to include mental health treatment.

☐ Medical, mental health treatment and dental care at Marshfield Clinic/Family Health Center including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.

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.

☐ Marshfield Clinic/Family Health Center providers should try to contact me before providing care at 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: Release of Medical Information, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

  White: Medical record Yellow: Legal guardian