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 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.

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, 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 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 Information, Marshfield Clinic Health System, 1000 North Oak Avenue, Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

