Patient name			
MHN	DOB	Age	Gender

Treatment of Minors in Parent/Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic/Family Health Center 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 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 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
- ☐ Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic/Family Health Center

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 _____ /_____ /_____

☐ 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 further agree to reimburse Marshfield Clinic/Family Health Center 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 | Relationship to patient

_____ _____ _____/_____/_____

Child's parent/legal guardian address | Parent/Legal guardian phone number | Signature date (m/d/y)

Send completed form to: Release of Medical Information, Marshfield Clinic, 1000 N. Oak Ave., Marshfield, WI 54449
Fax: 715-221-6992 E-mail: medicalrecords@marshfieldclinic.org

