Patient name			
MHN	DOB	Age	Gender

Treatment of Minors – Limited (One Time Use)

Consent

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) accompany any minor children (17 years old or younger) to their medical/dental/mental health appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical/dental/mental health treatment appointment, the parent or legal guardian must sign this Consent – Treatment of Minors – Limited (One Time Use) form.

Parent or legal guardian name _____

Patient name _____

Appointee (person authorized to consent) _____ Relationship to child _____

☐ I consent to care and treatment for my child related to his/her medical/dental/mental health treatment appointment 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:

on *(date – month/day/year)* _____ /_____ /_____

for *(reason for appointment – specify approved care/procedures/tests/immunizations)* _____

_____

with *(health care provider name)* _____

☐ My mature child, age _____ (not less than 16) can attend this medical/dental/mental health treatment appointment alone.

If there is a need to reach me during my child's appointment to discuss further care or treatment, I may be reached at the following phone numbers:

Home (_____) _____ – _____ Work (_____) _____ – _____

Cell (_____) _____ – _____ Other (_____) _____ – _____

I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services.

_____ _____

Child's parent/legal guardian signature Relationship to patient

_____ _____ /_____ /_____

Print child's parent/legal guardian name Signature date (month/day/year)

_____ _____

Child's parent/legal guardian address Child's parent/legal guardian phone number

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

