Patient name			
MHN	DOB	Age	Gender

Treatment of Minor/Adult Ward in Parent/Legal Guardian Absence

Consent Revocation

Patient address _____

City _____ State _____ ZIP _____

Home telephone number _____

I hereby revoke the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) generated by me on

(date: month/day/year) _____ /_____ /_____ to:

Appointee name _____

Address _____

City _____ State _____ ZIP _____

I understand that this revocation of the Consent – Treatment of Minors in Parent/Legal Guardian Absence or Consent – Treatment of Adult Ward Legal Guardian Absence form(s) will not be valid if Marshfield Clinic Health System has already used or allowed for the consenting of care in reliance upon my authorization.

_____ _____ _____/_____/_____

Patient signature (Person authorized to consent for patient) (Relationship to patient) Signature date (m/d/y)

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

