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

