PARENTAL AUTHORIZATION FOR SUBSTITUTED CONSENT FOR MINOR

Name of Minor Patient: ____ **Date of Birth:** _______________

MRN: ____

PARENT / GUARDIAN INFORMATION	
Parent/Guardian Name:	Telephone #:
Street Address:	Birth Date:
City/State:	Zip Code:

I, ____, the undersigned parent or legal guardian of the above named minor, in the event I cannot be contacted through reasonable efforts, hereby authorize the following individual(s) to consent to and authorize any and all medical care for the minor patient named above, which is deemed necessary by the healthcare providers of Froedtert & the Medical College of Wisconsin Community Physicians. I further authorize these individual(s) to receive protected health information directly relevant to, and for purposes of, his/her involvement in the treatment or payment related to the treatment:

____ ____________________________________
Name Relationship to Minor Patient

____
Address

____ ____________________________________
Name Relationship to Minor Patient

____
Address

**The above named individual(s) must be 18 years of age or older.

I understand and agree that I am financially responsible for all health care provider services rendered.

This Authorization is valid for a period of one year from the date of signature unless otherwise specified below.

This Authorization shall be valid for the following period of time (not to exceed one year): Beginning on __________________ and ending on _______________.

I understand that in order to revoke this authorization, I must submit a written revocation to the Health Information Management department at Froedtert & the Medical College of Wisconsin Community Physicians. Such revocation will not apply to information used or disclosed in carrying out this designation prior to the time of revocation.

____ ____
Signature of Parent or Legal Guardian Signature and Title of Witness (F&MCW-CP Staff)

______________________ ____
Date Printed Name of Witness

____
Date

__NOTE:__ **This authorization must be notarized if not signed and witnessed by Froedtert & the Medical College of Wisconsin Community Physicians staff.**

__Notary Public__

STATE OF______________________________, COUNTY OF ____

BEFORE ME, an officer duly authorized in the State and County aforesaid to take acknowledgements, personally appeared __________________________________ and _____________________, known to me and known to be the persons described in and who executed the foregoing Authorization, and they acknowledged before me that they executed the same freely and voluntarily for the uses and purposes therein expressed.

WITNESS our hands and official seals at _______, in the County and

State aforesaid this _______ day of ___________________, 20 _______.

____
NOTARY PUBLIC

My Commission expires: _______________________________

(F09870 02/14)