

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF CHILD

ProHealth Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-262-928-4465 (TTY: 1-866-327-8877).
ATENCIÓN: Si habla español, tenemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (TTY: 1-866-327-8877).
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-262-928-4465 (TTY: 1-866-327-8877).

We, _____ and _____ of _____, _____, Wisconsin, United States of America make oath and say that we are the lawful parent(s) of the child listed below and there are no court orders now in effect that would prohibit us from conferring the power to consent upon another person.

Information of Child

_____, _____, born _____, _____ at _____

And residing at _____, _____, Wisconsin, United States of America.

We hereby authorize and appoint _____ of _____, _____,

Wisconsin, United States of America, as our agent. Our agent may consent to our child's

- For minor matters (clinic visits, x-rays, labs, immunizations, etc.)
- For major matters (surgery, serious illness), it is understood that ProHealth Care will call us, the parents, for consent to treatment

Parent contact phone number _____.

Our agent may have access to any and all records, including, but not limited to, insurance records regarding any such services.

The purpose of this instrument is to give _____ the power and authority to consent to medical treatment of our child and this power and authority will be effective as of the _____ day of _____, _____ and will end (be revoked) on _____ day of _____, _____.

1. We give this consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency.
2. Any questions or concerns regarding this authorization may be directed to us at:

Name: _____

Name: _____

Street Address: _____

Street Address: _____

City, State: _____, Wisconsin

City, State: _____, Wisconsin

Zipcode: _____

Zipcode: _____

Phone Number: _____

Phone Number: _____

Secondary Phone: _____

Secondary Phone: _____

Email: _____

Email: _____

IN WITNESS WHEREOF, we hereunto sign our names at _____, Wisconsin this _____ day of _____, 20_____

