Scenic Bluffs
COMMUNITY HEALTH CENTERS

Substituted Consent for Treatment

To comply with Wisconsin law, Scenic Bluffs Community Health Center requires that a legal guardian (guardian appointed by a court) consent to care when they are unable to attend appointments. In the event that a legal guardian is unable to consent to care, the legal guardian may delegate the right to consent to another adult. In the event that a patient presents for a non-urgent appointment without a legal guardian or a signed consent, treatment may be denied.

Release of Information: To ensure that the Parent Substitute(s) has access to Patient Health Information needed to make informed consent decisions, I/We authorize Scenic Bluffs Community Health Center to provide the Parent Substitute(s) with Patient Health Information relating to the Minor Patient. "Patient Health Information" means all medical records and treatment records relating to the Minor Patient which are protected and confidential under 42 C.F.R. Part 2, Wis. Stat. §§51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Regulations"), 45 C.F.R. Part 160 and Part 164, subparts A and E.

It is only necessary to complete section 1 and 3 if granting permission for patient to be seen without a parent/guardian.

Section 1:

Patient's name: _____ **Patient's Date of Birth:** _____

During the period: _____ to _____ ☐ **or until patient is 18 years of age**
(Start Date) (Ending Date)

In the event Scenic Bluffs Providers need to contact you before providing care please provide the following information:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

Would you like the patient to be seen without a patient/guardian present? ____Yes ____No
(Parent/Guardian may be required to attend for certain procedures)

Section 2:
I delegate the right to consent to the following adult(s)

Adult Appointee's Name: _____

Relationship (to patient): _____

Appointee's Address: _____

Appointee's Phone Number: _____

Section 3:
I agree to reimburse Scenic Bluffs Community Health Center for the cost of rendering these services to the extent that my insurance does not pay for these services.

_____ _____
Parent/Legal Guardian Signature **Relationship**

_____ _____
Parent/Legal Guardian Printed Name **Date**