Winona Health

Authorization to Treat a Minor or Dependent Adult (Adult Not Present)

I, _____ give Winona Health _____
(Custodial Parent or Guardian Name -- please print) (Department)

permission to treat my child/dependent adult on _____ providing care for following
(Date/s)

condition(s) or treatment plan _____.

I agree to reimburse Winona Health for services rendered, if applicable. This consent applies only to the date(s) listed and is not to exceed 12 months from the date this document is signed. This consent can be revoked, in writing, at any time.

I agree to be available by phone in the event there is a medical emergency or unexpected change in my child's/dependent adult's condition or plan of care. I understand that if I cannot be reached by phone, Winona Health may not be able to initiate treatment.

_____ _____/_____/_____
Child/Dependent Adult Name (please print) Child/Dependent Adult Date of Birth

_____ (_____) _____
Custodial Parent/Legal Guardian Name (please print) Phone Number **(REQUIRED)**

(_____) _____
Alternate Phone Number

Custodial Parent/Legal Guardian Address **(REQUIRED)**:

_____
Street/PO Box City State Zip Code

_____ _____
PARENT/LEGAL GUARDIAN SIGNATURE DATE TIME Relationship to minor/dependent adult

TWO WITNESS SIGNATURES REQUIRED FOR VERBAL/PHONE CONSENT:

_____
WITNESS SIGNATURE DATE TIME

_____
WITNESS SIGNATURE DATE TIME

For Temporary Delegation of Parental/Guardian Rights for Medical Decision-making, refer to form 2079A.

3352A
2/6/2023

PO Box 5600 • 855 Mankato Avenue • Winona, MN 55987 TEL: 507.454.3650 • FAX: 800.944.3960 • winonahealth.org