ThedaCare
Orthopedic Care

Minor Patient Name: _____ Date of Birth_____

1. I am a parent or the court appointed legal guardian with medical decision-making authority of the Minor Patient, and authorized to make health care decisions on behalf of the Minor Patient.

2. I authorize ThedaCare providers (including healthcare profession students/residents) to provide the Minor Patient with emergency, urgent and routine medical care and treatment, including all diagnostic procedures.

3. I authorize ThedaCare to provide any Parent Substitute, if there Is a delegation of parental power form on file for this child, with Protected Health Information relating to the Minor Patient. "Protected 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.

4. This authorization is valid until revoked as described below, upon the Minor Patient reaching the age of majority or until _____ (insert desired date). Parent or legal guardian Is responsible to notify ThedaCare Orthopedics of any changes. This authorization may be changed or revoked at any time prior to that expiration date by providing ThedaCare with written notice. I am aware that any change or revocation will not be effective until after the date written notice is received.

I have carefully read, considered, and agree with this consent form before signing it.

SIGNATURE OF PARENT(S) OR LEGAL GUARDIAN(S):

(One Signature Required.)

Signature_____ Date_____ ___ Parent of Minor ___ Legal Guardian

Signature_____ Date_____ ___ Parent of Minor ___ Legal Guardian

CONTACT INFORMATION OF PARENT(S) OR LEGAL GUARDIAN(S):

Name_____ Relationship to Minor_____ Phone_____

Name_____ Relationship to Minor_____ Phone_____