Addressograph

Minor Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

POWER OF ATTORNEY FOR TREATMENT OF MINOR PATIENT – NOT IN FOSTER CARE

To facilitate medical care and treatment of the "Minor Patient", _____ (print name), by Gundersen Clinic, Ltd., Gundersen Lutheran Medical Center, Inc., Gundersen Boscobel Area Hospital and Clinics, Gundersen Palmer Lutheran Hospital and Clinics, Gundersen St. Joseph's Hospital and Clinics, and Gundersen Tri-County Hospital and Clinics (collectively "Gundersen"), the undersigned parent(s) of the Minor Patient hereby agree(s) as stated herein. I am a parent/We are parents of the Minor Patient authorized to make health care decisions on behalf of the Minor Patient.

Foster Care or Native American Indian Children – STOP HERE – this form cannot be used without Court approval.

IDENTIFY THE MINOR PATIENT'S PRIMARY STATE OF RESIDENCE:

☐ Wisconsin

ALL parents with legal custody must sign for this form to be valid.

Select One:
- ☐ **We have shared legal custody.** *(BOTH parents must sign.)*
- ☐ **I have sole legal custody.** *(provide Court Order showing sole legal custody)*
- ☐ **Minor Patient's other parent is deceased.**

Duration: *Select **ONLY ONE**.*

- ☐ This document is valid for one (1) year, or a shorter period beginning on _____, and expiring on _____.
- ☐ The named Parent Substitute(s) is a relative/are relatives, and I/we intend the delegated parental power to remain in effect until revoked or until the Minor Patient is 18 years of age.

☐ Minnesota

Requires Notarized signature of ONE parent with legal custody.

Duration:

- ☐ This document is valid for one (1) year, or a shorter period beginning on _____, and expiring on _____.

*Minnesota law allows duration of one year or less. **Parent's signature must be witnessed by a Notary.***
The parent signing this form must provide the other parent with a copy within 30 days, some exceptions apply.

☐ Iowa

Requires signature of ONE parent with legal custody.

Duration: *Select **ONLY ONE**.*

- ☐ This document is valid for one (1) year, or a shorter period beginning on _____, and expiring on _____.

DELEGATION OF PARENTAL POWER – SELECT A or B:

☐ **A. The power to provide informed consent for ONLY ordinary or routine health care and treatment, including dental care**, ***excluding*** consent for major elective surgical procedures, extraordinary procedures, and experimental treatment. This includes the power to sign the Authorization for Treatment/Payment/Disclosure of Protected Health Information form for the care and treatment provided under this document.

☐ **B. Full parental power to provide informed consent to all health care, including but not limited to, dental care, outpatient mental health care, outpatient alcohol and drug treatment, major elective surgical procedures, hospital discharge, but *excluding*** consent for extraordinary procedures, and experimental treatment. This includes the power to sign the Authorization for Treatment/Payment/Disclosure of Protected Health Information form and other disclosures of Protected Health Information to third parties for the care and treatment provided under this document.

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Disclosure of Protected Health Information to Parent Substitute(s). I/We also authorize Gundersen to disclose Protected Health Information about the Minor Patient to the Parent Substitute(s) as needed to facilitate the Parent Substitute(s) in exercising the delegated power. "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.

Identification of Parent Substitute(s). I/We appoint these Parent Substitute(s) with the delegated power as indicated herein. If two Parent Substitutes are identified, either may exercise the delegated power.

Parent Substitute #1:	**Parent Substitute #2:**
Printed Name:	**Printed Name:**
Relationship to Minor Patient:	**Relationship to Minor Patient:**
Address: (include Street, City, State, Zip)	**Address: (include Street, City, State, Zip)**
Phone Number:	**Phone Number:**
Statement: I, the Parent Substitute named above, understand the parent(s) named in this form has/have delegated to me the powers specified in this Power of Attorney for Treatment of Minor Patient. I hereby declare that I am at least 18 years of age and I have read this form, understand the powers delegated to me by this form, am fit, willing and able to undertake those powers, and accept those powers. **I understand this does not make me the Minor Patient's Legal Guardian and I cannot delegate the specified powers to a third party.**	**Statement**: I, the Parent Substitute named above, understand the parent(s) named in this form has/have delegated to me the powers specified in this Power of Attorney for Treatment of Minor Patient. I hereby declare that I am at least 18 years of age and I have read this form, understand the powers delegated to me by this form, am fit, willing and able to undertake those powers, and accept those powers. **I understand this does not make me the Minor Patient's Legal Guardian and I cannot delegate the specified powers to a third party.**
⇨ **Signature of Parent Substitute #1:**	⇨ **Signature of Parent Substitute #2:**
⇨ **Date:**	⇨ **Date:**

LIMITS: This document may **not** be used to delegate the power to consent to:

- Marriage or adoption of the Minor Patient
- Performance or inducement of an abortion on or for the Minor Patient
- The termination of parental rights to the Minor Patient
- To place the Minor Patient in a foster home, group home or inpatient treatment facility.

No deprivation: This delegation of parental power does not deprive a parent of any of his or her powers regarding the care and custody of the Minor Patient, whether granted by court order or force of law.

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Revocation: Any parent signing this document may revoke this delegation at any time prior to the expiration date by providing written notice to Gundersen Health System, ATTN: Patient Record Services Manager, Mail Stop AVS-001, 1900 South Ave., La Crosse, WI 54601.

Release: I/We agree to release Gundersen Health System, its affiliates, and subsidiaries from liability for any claims resulting from its or their provision of patient care and release of Protected Health Information in reliance upon this document.

Statement of Parent(s): I/We have carefully read and considered this consent form before signing it.

Parent #1	**Parent #2**
Printed Name:	**Printed Name:**
Address: **(include Street, City, State, Zip)**	**Address:** **(include Street, City, State, Zip)**
Phone Number:	**Phone Number:**
⇨ **Parent #1 Signature:**	⇨ **Parent #2 Signature:**
Parent's signature MUST be witnessed & dated. If Minnesota, witness must be a Notary.	**Parent's signature MUST be witnessed & dated. If Minnesota, witness must be a Notary.**
Witness for Parent #1	**Witness for Parent #2**
I know the parent identified above, believe him or her to be of sound mind, and believe he or she is signing this document voluntarily. **I personally witnessed this parent sign this document on this date.** I certify that I am: (i) at least 18 years of age, (ii) Not related to this parent by blood, marriage or adoption, and (iii) Not named as a Parent Substitute.	I know the parent identified above, believe him or her to be of sound mind, and believe he or she is signing this document voluntarily. **I personally witnessed this parent sign this document on this date.** I certify that I am: (i) at least 18 years of age, (ii) Not related to this parent by blood, marriage or adoption, and (iii) Not named as a Parent Substitute.
Witness Printed Name:	**Witness Printed Name:**
⇨ **Witness Signature:**	⇨ **Witness Signature:**
⇨ **Date**:	⇨ **Date**:

PARENTS, YOU MUST SUPPLY THE REQUIRED CUSTODY DOCUMENTS:
• Most recent Divorce/Custody Order or Paternity Order • Other Court Order: 1) juvenile court approval (foster care), 2) Indian Tribal Court approval, 3) extended duration court approval.