

# 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

