Minor Patient Name: ________________________

Date of Birth: ______________________________

Medical Record Number: _____________________

GUNDERSEN
HEALTH SYSTEM®

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 Moundview Hospital and Clinics, Gundersen Palmer Lutheran Hospital and Clinics, Gundersen St. Joseph's Hospital and Clinics, Gundersen Tri-County Hospital and Clinics, and Gundersen St. Elizabeth's 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.** ☐ **Minor Patient's other parent is deceased.** - **Duration:** If the named Parent Substitute(s) <u>is a relative(s)</u>, I/we intend the delegated parental power <u>to remain in effect until revoked</u> or until the Minor Patient is 18 years of age. If the named Parent Substitute(s) <u>is NOT a relative(s)</u>, this document is valid for one (1) year. ☐ Check here for a shorter period beginning on ____________ and expiring on _____________.
☐ **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:** This document is valid for one (1) year, or a shorter period beginning on ____________________ and expiring on _________________.

DELEGATION OF PARENTAL POWER:

This document will automatically allow parental 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 Patient Authorization and Service Terms form for the care and treatment provided under this document.

Please check box below if you would like to delegate full powers to the parent substitute(s):

☐ 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 Patient Authorization and Service Terms 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.

☐ **MyChart Proxy Access:** By checking this box, you are authorizing the Parent Substitute(s) to have proxy access to the Minor Patient's MyChart account, valid for the same time this document is valid (on page 1).

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:**
Date of Birth: (required for MyChart Proxy access)	**Date of Birth:** (required for MyChart Proxy access)
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:**

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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.

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: Privacy Office, Mail Stop NCA2-08, 1900 South Ave., La Crosse, WI 54601.

Release: I/We agree to release Gundersen, 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
Printed Name:
Address: (include Street, City, State, Zip)
Phone Number:
⇨ **Parent #1 Signature:**
⇨ **Date:**

Parent #2
Printed Name:
Address: (include Street, City, State, Zip)
Phone Number:
⇨ **Parent #2 Signature:**
⇨ **Date:**

MINNESOTA ONLY: Parent(s) signature **MUST** be witnessed by a Notary.

In the State of Minnesota, County of_____. Signed before me on this _____ (date).

_____, Notary
SIGNATURE – Notary Public

_____
NAME (Printed) – Notary Public

My commission expires: _____ NOTARY SEAL