Marshfield Area Respite Care Center, Inc.
MARCC
P.O. Box 485
Marshfield, Wisconsin 54449-0485
715-384-8478

CONSENT FOR TREATMENT

NAME OF PARTICIPANT_____

I, _____, as representative for the above named participant in the Marshfield Area Respite Care Center, authorize Dr._____, or his/her designee, to treat any condition requiring emergency treatment or acute care at Marshfield Medical Center. If admission is required, I further authorize that also. This consent shall remain in full force until my arrival at Marshfield Medical Center.

_____ _____
Representative's Signature Relationship

_____ _____
MARCC Representative's Signature/Title Date