Partnership Health Center
401 Railroad St
Missoula, MT 59802
(406) 258-4789

Parental Consent

Release for treatment of a minor child

CHILD'S INFORMATION			
Last name	First name	MI	Date of birth

PLEASE READ CAREFULLY: It is best practice to see minors with their parent or guardian present. If you cannot come to an appointment with your child, we are legally obligated to have your written authorization for another adult to bring them in *before* we deliver care. Even with this consent on file, we will always call before we begin a non-urgent evaluation or provide treatment. In an emergency situation, we will deliver care and contact you as soon as possible. Urgency will be determined by our medical professionals. Be advised that your child's protected health information may be shared with the person to whom you give consent; if you do not want information to be shared, please specify your wishes in the limitations section of this form. Our clinical staff and providers reserve the right to postpone any non-urgent procedure if we are unable to contact you by phone at the time of an appointment.

PARENT OR LEGAL GUARDIAN INFORMATION		
Last name	First name	Relationship to child
Cell phone number	Alternate phone number	Legal Guardian?
		[ ] Yes [ ] No
Last name	First name	Relationship to child
Cell phone number	Alternate phone number	Legal Guardian?
		[ ] Yes [ ] No

DESIGNATED ADULTS (PROXIES)

Which other adults are authorized to bring your child in for an appointment at PHC?

Name: ____ Relationship to child: ______________________

Name: ____ Relationship to child: ______________________

Name: ____ Relationship to child: ______________________

MINOR'S HEALTH HISTORY

Primary Care Provider: ____

Clinic Name: ______________________________________ Phone number: ______________________________

Please note all conditions for which your child is currently receiving treatment: ______________________________

____

(CONTINUED ON OTHER SIDE)

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MINOR'S HEALTH HISTORY CONTINUED

Current medications: ____

Allergies to medications: ____

Please list any other allergies: ____

Note any other significant medical information: ____

____

LIMITATIONS

Are there any limitations you would like to place on the treatment PHC may provide to your child?

[ ] None
[ ] Limited to: ____
____

Are there any limitations on the time frame for which this authorization is given?

[ ] None
[ ] Limited to: ____
____

MINOR'S INSURANCE INFORMATION

Responsible Party's mailing address: ____

Minor's Insurance Carrier: ___________________________________ Subscriber number: ________________________

Group number: ___________________________ Which parent/guardian carries this insurance? ___________________

AUTHORIZATION

I have the legal right to pre-authorize this facility to deliver treatment to my (our) child, ___________________________ ____________________. I request and authorize Partnership Health Center and its personnel to deliver health care to my child, listed above. I understand that prior to each visit, I will be contacted at one or both of the numbers provided on this form. I understand that in an emergency situation, care for my child will be initiated immediately and PHC personnel will contact me as soon as possible. I understand that I am providing authority to the Designated Adult(s) to exercise his or her own best judgement upon the advice of licensed PHC personnel. I accept financial responsibility for services provided.

Parent/Guardian Signature: ____ Date: ___________________

Parent/Guardian Signature: ____ Date: ___________________

<u>Note:</u> Parents or legal guardians may revoke this authorization in writing at any time.
Unless otherwise revoked, PHC will consider this authorization as valid consent until the minor child turns 18.