Partnership Health Center Parental/Legal Guardianship Consent Form

Office Use Only

Please review the following information and authorization for medical treatment if/when you cannot be present at the time of treatment. Sign if you wish to authorize Partnership Health Center to provide medical treatment for your child.

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my (our) dependent for their appointment scheduled on _____. I (we) request and authorize Partnership Health Center and its personnel to deliver the medical care to my (our) dependent listed below. We understand that we will be notified by telephone (at the contact number listed below) if my(our) dependent is being seen under an emergency situation.

Identify any limitations in the kind of medical services for which this authorization is given.
___ None
___ Limited to:_____
If the nature of the medical care is not routine, please note we will try to contact you at the telephone numbers listed below.

PATIENT INFORMATION

Patient's Last Name: _____
Patient's First Name: _____
Date of Birth: _____/_____/_____
Month Day Year

Patient's Social Security Number: _____

Sex: ☐ Male ☐ Female Age _____

Ethnicity: ☐ Hispanic ☐ Black ☐ White ☐ American Indian ☐ Asian/Pacific Islander ☐ Other _____

Patient's Address:_____
_____
_____ _____ _____
City State Zip Code

Who is the patient's regular doctor?
Name: _____
Telephone: _____
Address: _____
_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____First Name: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____
Address: _____

Father
Last Name: _____ First Name: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____
Address: _____

Legal Guardian, If Applicable
Last Name: _____First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____
Address: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Beeper/Cell: _____

INSURANCE INFORMATION

Is your child covered by Medicaid Insurance?
❑ No ❑ Yes: Medicaid ID # _____

Which Plan?
❑ Healthy Montana Kids (HMK)
❑ Healthy Montana Kids Plus (HMK plus)
❑ Other: _____

Does your child have other insurance?
❑ No ❑ Yes:
Insurance Carrier: _____
Subscriber:_____
Subscriber SSN:_____
Policy Number: _____
Group Number: _____

Insurance Billing Address: _____
_____

PARENTAL CONSENT FOR HEALTH CENTER SERVICES

I give permission for my child to be seen by a medical provider at Partnership Health Center as indicated above. I understand the Partnership Health Center will inform me of any emergency visits my child may have by phoning my contact telephone number. I give permission for Partnership Health Center to request and/or share my child's records as needed.

My signature indicates I have received a copy of the Notice of Privacy Practices.

X _____ _____

Signature of Parent/Guardian **Date**

HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the release of health information included with this form. My signature indicates my consent to release medical information as specified.

X _____ _____

Signature of Parent/Guardian **Date**