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

Parental Consent

Release for treatment of a minor child

11/20/19

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 legal guardian present. If you cannot come to an appointment with your child, we are legally obligated to have your written authorization *before* we deliver care. Even with this consent on file, we will make every effort to call you 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 (proxy) 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(S) 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

MINOR'S HEALTH HISTORY

Primary Care Provider: _____

Clinic Name: _____ Phone number: _____

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

_____

Current medications: _____

Allergies to medications: _____

Please list any other allergies: _____

Note any other significant medical information: _____

DESIGNATED ADULTS (PROXIES)

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

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

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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: _____

May your child come in for an appointment without you or without an approved adult proxy?

[ ] No
[ ] Yes, 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? _____

FOR MISSOULA COUNTY AND MINERAL COUNTY PUBLIC SCHOOL STUDENTS

_____ INITIAL HERE	In order for health staff at Partnership Health Center (PHC) to provide services to my (our) student/child, I authorize the Missoula County Public School (MCPS) District to release school records on a *need to know basis* to providers at PHC. I also authorize PHC to release medical records to the school on an *educational right to know basis*. I understand that any information that is needed to support the care and well-being of my student/child will be released. Information may include the following: prior evaluations, immunization records, class schedules, parental/legal guardian contact info, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information.
_____ INITIAL HERE	I give permission for my student/child's PHC care providers, including their behavioral health providers, to collaborate with MCPS staff in providing care, and in creating action plans to help my child succeed at school. I understand that PHC staff will be *participating as necessary* in student academic, attendance, and behavior meetings. PHC staff will protect student privacy in a manner that adheres to the Family Educational Rights and Privacy Act (FERPA).

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/Legal guardian Signature: _____ Date: _____

Parent/Legal guardian Signature: _____ Date: _____

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 turns 18.