401 Railroad St. W
Missoula, MT 59802
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partnershiphealthcenter.org

Parent/Guardian Consent

Release for treatment of a minor

9/1/2023

MINOR'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 be present at the appointment with your minor, we are legally obligated to have your written authorization *before* we treat your minor. In an emergency situation, we will provide treatment and contact you as soon as possible. Urgency will be determined by our medical professionals. Be advised that your minor's protected health information may be shared with the person (Designated Adult) 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 proper consent cannot be obtained before the time of an appointment.

ADULT INFORMATION – Other adults authorized to bring your minor for appointments at PHC

First and Last Name	Relationship to minor	Emergency Contact? *Does not grant verbal authorization – see below.	Accompany minor to visit?	Phone
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] Yes [ ] No	
		[ ] Yes [ ] No	[ ] 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: ______________________________

LIMITATIONS

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

[ ] None

[ ] Limited to: ______________________________

Minors under 14 must come to each appointment with a legal guardian or designated adult. May your minor age 14 and older come in for an appointment without you, or without an approved designated adult?

[ ] 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 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) Districts 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*.
______ INITIAL HERE	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) minor. I request and authorize Partnership Health Center and its personnel to deliver health care to my minor, listed above. I understand that every effort will be made to obtain proper consent prior to each visit. I understand that in an emergency situation, treatment for my minor 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 consent to treat my minor, and 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.