Livingston HealthCare
Billings Clinic Affiliate

Ranger Clinic 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 Ranger Clinic 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 during the 20_____/20_____ academic year. I (we) request and authorize Ranger Clinic 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.

Limitations:_____

_____

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: _____

Please complete and sign back page.

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: _____
Policy Number: _____
Group Number: _____
Insurance Billing Address: _____
_____

PARENTAL CONSENT FOR RANGER CLINIC

I give permission for my child to be seen by a medical provider at Ranger Clinic as indicated above. I understand Ranger Clinic will inform me of any emergency visits my child may have by phoning my contact telephone number. I give permission for Ranger Clinic 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 and Patient Rights (available at http://www.livingstonhealthcare.org/pdfs/PrivacyNotice.pdf).

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**