

## ADULT EMERGENCY MEDICAL TREATMENT RELEASE FORM

I, \_\_\_\_\_ hereby authorize emergency medical treatment for myself. I understand that this treatment will be administered by a qualified and licensed healthcare professional when, in the opinion of the attending healthcare professional, undue delay may endanger my life, or cause disfigurement, physical impairment, or unreasonable discomfort. This authority is granted only after a reasonable effort to reach my emergency contact at the contact numbers provided below has failed.

Emergency Contact # : \_\_\_\_\_ ( Please indicate type of #; i.e. mobile/pager) Secondary Contact # : \_\_\_\_\_ ( Please indicate type of #; i.e. mobile/pager)

1. Please list any allergies, medications, contact lenses, or any other pertinent information that may affect the level or type of care that might be required.

\_\_\_\_\_  
\_\_\_\_\_

2. Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's address: \_\_\_\_\_

### 3. Health Insurance Data

Enrolled Member: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy: \_\_\_\_\_

Group: \_\_\_\_\_ Contract: \_\_\_\_\_

This release form is completed and signed of my own free will for the sole purpose of authorizing medical treatment under emergency circumstances.

\_\_\_\_\_  
\_\_\_\_\_ Printed Name of

Participant Date

\_\_\_\_\_  
\_\_\_\_\_ Signature

