Medical Emergency Release Form

1. Patient Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**

2. Guardian Information (if applicable)

- **Name: _____**
- **Relationship: _____**
- **Contact Number: _____**

3. Emergency Details

- **Preferred Hospital: _____**
- **Physician Name: _____**
- **Known Allergies: _____**
- **Medications: _____**

4. Authorization

☐ I authorize emergency medical treatment as deemed necessary by medical professionals.

☐ I authorize the release of medical records if required.

5. Additional Instructions

- **Special Considerations: _____**

6. Signatures

- **Patient/Guardian Signature: _____ Date: _____**