ADULT MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As an adult over the age of eighteen, I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger my life, cause disfigurement, physical impairment, or undue discomfort if delayed. The authority is granted only after a reasonable effort has been made to reach my emergency contact.

Name of Adult:____

Reason for which release is intended:____

Address of Adult:____

City:____________________State:_____________Zip:_______Phone:___________________

Emergency Phone: ______________________________Date of Birth:___________________

Family Physician:____

Physicians Address: ____

City:____________________State:____________Zip:________Phone: __________________

List allergies, medication, contacts, or other pertinent comments:

Allergies:____

Medications:____

Comments/Other:____

Health Insurance Data:____

Company:________________________________Policy:_______________________________

Group:___________________________________Contract:____________________________

I further authorize the person who presents me to sign the Acknowledgement of Receipt of Notice of Privacy rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: ______/_____/___________Signed:____