

EMERGENCY INFORMATION AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone Number: _____

Medical Information:

Known Allergies: _____

Current Medications: _____

Chronic Conditions: _____

Insurance Information:

Insurance Provider: _____

Policy Number: _____

Group Number: _____

Primary Physician:

Name: _____

Phone: _____

Emergency Medical Consent

I, the undersigned, hereby authorize any physician, emergency medical technician, or hospital to provide emergency medical care, including but not limited to examination, diagnosis, treatment, and hospitalization for the above-named patient in the event of an emergency where I cannot be reached or am unable to provide consent. I understand that this consent is given in advance of any specific diagnosis or treatment required, and is intended to provide authority to the attending medical personnel to act in the best interest of the patient. I release and hold harmless the medical providers, their agents, and employees from any liability arising from their actions taken in good faith under this consent.

Authorization for Release of Information

I authorize the release of any medical information necessary to process insurance claims related to the emergency medical care provided. This authorization remains valid until revoked in writing.

Acknowledgment and Signature

By signing below, I acknowledge that I have read and understand the terms of this Emergency Information and Consent Form, and that I am legally authorized to provide this consent on behalf of the patient if the patient is a minor or otherwise unable to consent.

Signature of Patient or Legal Guardian

Printed Name

Date:

Relationship to Patient:

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