

HEALTH INFORMATION AND MEDICAL AUTHORIZATION FORM

Patient Information:

Full Name: _____

Date of Birth: _____

Gender (M/F/Other): _____

Address: _____

Phone Number: _____

Email Address: _____

Emergency Contact Information:

Contact Name: _____

Relationship: _____

Phone Number: _____

Health History and Conditions (Check all that apply):

☐ Diabetes	☐ Hypertension (High Blood Pressure)
☐ Heart Disease	☐ Asthma or Other Respiratory Conditions
☐ Allergies (Food, Medication, Environmental)	☐ Epilepsy or Seizures
☐ Bleeding Disorders	☐ Recent Surgery or Hospitalization
☐ Pregnancy	☐ Other (Specify): _____

Current Medications:

Known Allergies:

Primary Care Physician:

Name: _____

Phone Number: _____

Authorization and Legal Acknowledgments:

I hereby certify that the information provided above is complete and accurate to the best of my knowledge. I understand that withholding information or providing false information may jeopardize my health and safety. I authorize the release

of my medical information to necessary medical personnel in the event of an emergency. I acknowledge that this form is used for health and safety purposes and does not constitute medical advice or treatment. I release the organization and its agents from any liability arising from actions taken based on the information provided herein.

Signature and Consent:

Signature: _____
Printed Name: _____
Relationship to Patient (if not patient): _____

Witness (if required):

Witness Signature: _____
Printed Name: _____

PATIENT OR LEGAL GUARDIAN SIGNATURE

WITNESS SIGNATURE

Date: _____

Date: _____

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