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