



## Authorization for Emergency Medical Treatment Form

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize \_\_\_\_\_ (Operating Center's Name) to:

1. Secure and retain medical treatment and transportation, if needed; and
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In the event I cannot be reached, contact: \_\_\_\_\_ Phone: \_\_\_\_\_

contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Non-Consent Signature: \_\_\_\_\_

(Client, Parent or Guardian)

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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