



A Division of Rehab Resources, Inc.

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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