



Authorization for Emergency Medical Treatment

Counseling & Psychotherapy
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www.AllianceCounselingCenter.org

Personal Information

Name:	DOB:	Phone:
Address:		
Physician:		
Medical Facility:		
Health Insurance Company:	Policy No.:	
Allergies to Medications:		
Current Medications:		

In the event of an emergency, contact:

Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

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 Alliance Counseling Center 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.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature:	Date:
Client, Parent or Legal Guardian:	

Signed in the presence of program personnel

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:

Consent Signature: _____

Date: _____

Client, Parent or Legal Guardian: _____

Signed in the presence of program personnel