



## Authorization for Emergency Medical Treatment

Counseling & Psychotherapy  
818 NW 17th Avenue, Portland, Oregon 97209  
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### 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*