

# Authorization for Emergency Medical Treatment

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 Reins of Life, Inc. to:

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

Rider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

## Emergency Contacts

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Medical Facility: \_\_\_\_\_  
Health Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

## 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 listed below is unable to be reached.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/guardian if rider is under 18  
Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: (if different from above) \_\_\_\_\_

## 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/guardian if rider is under 18  
Print Name: \_\_\_\_\_  
Address: (if different from above) \_\_\_\_\_