Alliance™
COUNSELING CENTER

THE CENTER AT HERON HILL

Authorization for Emergency Medical Treatment

Counseling & Psychotherapy
22018 South Central Point Road, Canby, OR 97013
Phone: 503.221.4531 • Fax: 503.263.6278
info@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 Cetner 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