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| AUTHORIZATION TO ACT IN AN EMERGENCY |
| Name: Date of birth: |
| This authorization to act in a medical emergency will be in effect when the person’s legal representative, if any, cannot be reached or is delayed in arriving during a medical emergency situation.  I authorize the companywho manages my services to obtain all or part of the emergency medical services as I have checked here:   |  |  |  | | --- | --- | --- | | Emergency first aid | Paramedic care/“911” | Outpatient or urgent care | | Emergency surgery | Emergency dental care | Lab work/procedures | | Examinations | Immunizations | Other: |   Please describe any limitations to the authorizations checked:  I authorize the company to maintain and release a photograph of the person served for use only in emergency situations.  Yes  No  I understand that I may revoke these authorizations at any time.  Yes  No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Person served and/or legal representative Date |