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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:

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| [ ]  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 [ ]  NoI understand that I may revoke these authorizations at any time. [ ]  Yes [ ]  No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Person served and/or legal representative Date |