**Authorization Details:**

I, **[Your Full Name]**, the undersigned, am the **[Relationship to Patient]** of **[Patient’s Full Name]**. I authorize any licensed healthcare provider to provide necessary medical treatment or emergency care for **[Patient’s Full Name]** in the event of illness or injury.

**Patient Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | | |
| **Date of Birth:** | [DOB] | **Address:** |  |
| **Phone Number:** | [Phone] | **Allergies:** | [if any] |
| **Medical Condition:** |  | | |
| **Current Medications:** |  | | |

**Authorized Person(s):**

This authorization is given to **[Name(s) of Authorized Person(s)]**, with contact information as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Contact Name:** | |  | |
| **Relationship to Patient:** | [Relationship] | **Phone Number:** | [Phone] |
| **Alternate Phone Number: (optional)** | |  | |

**Authorized Medical Facilities and Providers:**

This authorization permits medical care at any licensed medical facility or by any licensed healthcare provider, including but not limited to **[Name of Specific Hospitals/Facilities, if desired]**.

**Authorization Scope:**

I authorize the following types of medical care for **[Patient’s Full Name]**:

|  |  |
| --- | --- |
| **Emergency Medical Treatment** (including transport by emergency services) |  |
| **Diagnostic Testing and Imaging** |  |
| **Prescription Medication Administration** |  |
| **Surgical Interventions** (only if deemed absolutely necessary by medical personnel) |  |
| **Routine Medical Care** |  |

**Insurance Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurance Provider:** | [Name] | **Policy Number:** | [Number] |
| **Group Number:** | [if applicable] | **Insurance Provider Contact Number:** | [Number] |

**Term of Authorization:**

This authorization shall remain valid until **[Expiration Date or Event].**

**Consent and Acknowledgment:**

I understand that I am responsible for all costs associated with medical treatment provided to **[Patient’s Full Name]** under this authorization unless covered by insurance. I release any healthcare provider from liability resulting from authorized treatment.

**Signature:**

I have read and understand this authorization form and confirm that all information provided is accurate to the best of my knowledge.

|  |  |
| --- | --- |
| **Signature of Patient (if applicable)** | [Date] |
| **Signature of Authorized Person**: | [Date] |
| **Printed Name of Authorized Person**: | [Full Name] |