

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT – ADULT

I. MEDICAL INFORMATION (please type or print legibly)

a. Name _____

Address _____

Telephone Number: Day (____) _____ Night (____) _____

b. Name of Nearest Relative _____

Address _____

Telephone Number: Day (____) _____ Night (____) _____

c. Physician's Name _____

Address _____

Telephone Number: Office (____) _____ Emergency (____) _____

d. Dentist's Name _____

Address _____

Telephone Number: Office (____) _____ Emergency (____) _____

e. Health Insurance Company Name _____

Policy Number _____ Telephone: (____) _____

f. Allergies _____

g. Current Medications _____

h. Special Health Needs _____

II. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize The University of Texas at Austin and its designated representatives to consent, on my behalf, to any medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are _____
to _____, 2 _____.

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

(Signature of Individual Providing Authorization) Date _____, 2 _____