

MEDICAL CONSENT FORM

Authorization for Medical Treatment

I, **[Full Name of Authorizing Person]**, born on **[Date of Birth]**, residing at **[Full Address]**, hereby authorize the following individual to receive medical treatment in the event of a medical emergency:

Patient's Full Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

In Case of Emergency, Contact:

Name: _____

Relationship: _____

Phone Number: _____

Consent to Medical Treatment

I hereby authorize licensed medical professionals, including physicians, nurses, emergency medical personnel, and any affiliated hospital or clinic staff, to perform any necessary medical treatment or procedures that they deem medically necessary for the individual named above.

This includes but is not limited to:

- Routine medical care
 - Emergency medical treatment
 - Surgical procedures
 - Hospitalization
 - Administration of medications
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Insurance Information (if applicable):

Insurance Company: _____
Policy Number: _____
Group Number: _____
Primary Care Physician: _____
Phone Number: _____

Special Medical Considerations:

(Please list allergies, medications, existing conditions, or other important information)

Authorization Duration

This consent is valid from **[Start Date]** to **[End Date]** unless revoked in writing before expiration.

Signature of Authorizing Person:

Signature: _____
Printed Name: _____
Date: _____

Notary Section (if required):

State of _____
County of _____

Sworn and subscribed before me on this ____ day of _____, **20**,
by _____ (Name of Signer).

Notary Public Signature: _____
Printed Name: _____
My Commission Expires: _____
[Seal]