



**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

In the event of a medical emergency involving illness or injury, I hereby authorize the InBalance team to secure and retain medical treatment, to transport as necessary to a medical facility, and to release our private health information to the medical provider. This consent includes emergency services, X-Ray, MRI, CAT, medication, hospitalization, surgery, or other medical treatment deemed necessary or lifesaving by medical personnel.

Participant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

If I cannot be reached, please contact: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Preferred Medical Facility: \_\_\_\_\_

Health Insurance Co: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

**I hereby give consent** for the InBalance team to secure emergency medical treatment for my child(ren) and/or myself in the event of illness or injury.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I do not consent** for the InBalance team to secure emergency medical treatment for my child(ren) and/or myself in the event of illness or injury.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_