EMERGENCY MEDICAL AUTHORIZATION PERMIT

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, I authorize the individuals listed below to act on my behalf.

This authorization is valid until such time as I withdraw the authorization. Authorized Person _____ Telephone Number _____ Authorized Person Telephone Number _____ Doctor Preferred ______ Telephone _____ Doctor's Address _____ Dentist Preferred Telephone Dentist's Address _____ Insurance Company ______ I.D. No. _____ **Important Medical Information** Allergies Current Medications or Treatments _____ Previous Operations or Hospital Confinements _____ Date of Birth Name (Print or type) Number Street Apt# City State Zip Signature Date