11.2.9 CONSENT FOR EMERGENCY MEDICAL CARE

Client Name: _____
Medical
Conditions: _____

_____

Drug
Allergies: _____

_____

Physician's Name: _____
Physician's
Address: _____
Physician's Phone
Number(s): (_____)_____-_____ (_____)_____-_____

MEDICAL FACILITY DESIGNATED BY CLIENT TO PROVIDE EMERGENCY CARE:

Facility: _____
Phone
Number(s): (_____)_____-_____ (_____)_____-_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____

Address: _____

Relationship: _____
Phone
Number(s): (_____)_____-_____ (_____)_____-_____

I, _____, authorize the Montrose Center staff to notify my physician and/or emergency contact listed above in case of a medical emergency. In the event of an emergency, I hereby authorize and direct the Center to take emergency action on my behalf.

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Patient Records, § 42 CFR, Part 2, § 33 of Public Law 91-616 as amended by Public Law 93-282, HIPAA Privacy Act §45 CFR 160 – 164, and all applicable state and local laws, rules, and regulations; and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g.: probation, parole, etc.). A photographic copy of this authorization shall be considered as valid as the original.

This consent expires one (1) year after my last date of service (individual, family, or group session) at the Montrose Center, or ____ other _____unless I revoke it as provided for above.

_____ ____/____/____ _____
Client's Signature Date Parent, Guardian, or Authorized Representative's Signature