Emergency Medical Condition (EMC) Examination and/or Medical Treatment/Release of Information of a Minor Authorization Form

This form authorizes a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by a parent or legal guardian, and it is not feasible or practical to contact them.

Patient Name: _____ Date of birth: _____
Patient Name: _____ Date of birth: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I, the undersigned, hereby grant my authorization and consent for CloudMD medical provider (hereinafter referred to as the "Designated Adult") to administer an Emergency Medical Condition (EMC) examination and/or provide general treatment for any injuries or illnesses experienced by the minor.

I do hereby grant my authorization and consent for _____ (hereafter "designated adult") to administer an emergency medical condition (EMC) examination and/or general treatment for any minor injuries or illnesses experienced by the minor. If the injury or illness is life-threatening, I authorize the designated adult to summon any and all the professional emergency personnel to attend, transport, and treat the minor and to issue consent for any x-ray, anesthetic, blood transfusion, medication or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

I accept full financial responsibility for all expenses incurred for such medical care.

This authorization is granted in advance of any medical treatment, empowering the Designated Adult to act in the minor's best interests and to exercise discretion in consultation with medical or emergency personnel as needed.

I further agree that unless I specify otherwise, medical information regarding the minor's diagnosis, treatment, and account balance may be disclosed to the biological mother, biological father, stepmother, stepfather, the Designated Adult named above, referring physicians, other healthcare professionals involved in the care of my child, and my insurance company or companies.

Signed this [date]: _____

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____

Witness Signature: _____

Witness Printed Name: _____