THE UNIVERSITY OF TEXAS AT AUSTIN

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT- ADULT

I. **MEDICAL INFORMATION** (please type or print legibly)

a. Name _____
(last, first, middle)

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Day (___) _____ Night (___) _____

b. Name of Nearest Relative _____
(last, first, middle)

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Day (___) _____ Night (___) _____

c. Physician's Name _____

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Office (___) _____ Emergency (___) _____

d. Dentist's Name _____

Address _____
(street or P.O. box, city, state, zip code)

Telephone Number: Office (___) _____ Emergency (___) _____

e. Health Insurance Company Name _____

Policy Number _____ Telephone (___) _____

f. Allergies _____

g. Current Medications _____

h. Special Health Needs _____

II. **EMERGENCY MEDICAL AUTHORIZATION**

I, the undersigned, do hereby authorize The University of Texas at Austin and its agents or representatives to consent, on my behalf, to any medical/hospital care or treatment (including locations outside the U.S.) to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

The effective dates of this authorization are _____ to _____ 20____.

I am eighteen years of age or older, have read the above authorization, and confirm that the information contained therein is true and accurate.

_____ Date_____20_____ .
(Signature of Individual Providing Authorization)