



**BEAMING INC.**  
**Authorization for Emergency Medical Treatment**  
**(Choose A or B)**

**A. Consent Plan:**

In the event of an emergency where medical treatment is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize BEAMING, Inc. to 1. Secure and retain medical treatment and transportation if needed. 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and/or any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the person below is unable to be reached.

In the event I (parent, guardian), \_\_\_\_\_ cannot be reached (phone \_\_\_\_\_), please contact the following:

Contact #1: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Contact #2: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Group # \_\_\_\_\_ Member # \_\_\_\_\_

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

**B. Non-consent Plan**

I do not give consent for emergency medical treatment/aid for myself or my minor child/ward in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event that emergency treatment/aid is required, I wish the following procedure to take place:

\_\_\_\_\_

\_\_\_\_\_

Non-consent Signature: \_\_\_\_\_ Date: \_\_\_\_\_