**SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

**ACKNOWLEDGEMENT OF EMERGENCY CARE PROCEDURES – Side 1**

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Individual’s Name Case Date of Birth

In case of injury, accident or illness which requires prompt attention while the above individual is located at a Sanilac County Community Mental Health Authority (SCCMHA) facility or residential setting under contract with SCCMHA, and/or while he/she is physically participating in a SCCMHA program or activity, SCCMHA Employees and Contract Providers of service, will provide the following:

FIRST AID

URGENT CARE (SUCH AS CPR IN LIFE THREATENING SITUATIONS)

TRANSPORTATION TO HOSPITAL VIA AMBULANCE OR AGENCY/HOME VEHICLE

Please indicate preferred hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: SCCMHA Employees and Contract Providers will attempt to accommodate hospital preference. However, the closest service available will be used for life threatening situations, or the setting recommended by the treating physician. Please also note that ambulance services may be required to transport to the nearest hospital.

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

Sanilac County Community Mental Health Authority, its Officer/designee, or Medical Records Department, is hereby authorized to release information concerning the above named individual to providers of emergency medical services, including the following as applicable:

1. Name, address and phone number of the individual and Home-Care Provider (if any).
2. Name, address and phone number of the Representative Payee, Conservator, Guardian, and/or Legal Representative (if any).
3. Name, address and phone number of the next of kin.
4. Essential medical information including: diagnosis, current medical or psychological condition(s) as indicated in the individual’s record, allergies, medications (including prescribing physician, administration times and dosage), medical insurance, primary language used and understood.
5. Alcohol and drug abuse records protected under 42 Code of the Federal Regulations Part 2.
6. HIV infection, AIDS and AIDS related complex (ARC) records.

Please note any special procedures necessary for release of information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: This consent does not authorize SCCMHA employees to consent to medical treatment for the above individual. Consent is the legal responsibility of the individual or legal representative/guardian (if any), or of the next of kin, in the case of an emergency. The individual/legal representative (if any) may designate other individuals (not SCCMHA staff) to authorize medical treatment on the reverse side of this form.

***PLEASE TURN PAGE OVER - CONTINUED ON REVERSE SIDE***

**SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

**ACKNOWLEDGEMENT OF EMERGENCY CARE PROCEDURES – Side 2**

***CONTINUED FROM FRONT SIDE OF FORM***

Individual Name Case # Date of Birth

**AUTHORIZATION TO CONSENT TO EMERGENCY TREATMENT**

The persons listed below are hereby authorized to consent to medical treatment for the above individual in the case of an emergency when he/she or the legal representative (if any), is unable or unavailable to authorize emergency treatment: **(Please write in information on anyone you authorize to do this.)**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE # RELATIONSHIP

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE# RELATIONSHIP

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE# RELATIONSHIP

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I will be notified of incidents which require emergency services, and I acknowledge that I was given an opportunity to ask questions and that they were answered to my satisfaction.

**By signing below, I consent to the release of information as specified above and designate the person(s) listed above (if any) as having my authorization to consent to emergency treatment.**

This consent expires one year from the date of signature below unless revoked in writing. I understand that this consent can be revoked at any time.

Signature Date

Guardian/Legal Representative Signature (if any) Date