Emergency Room Consent for Treatment

Patient Name: _____

Date of Birth: _____

Insurance Provider: _____

Policy Number: _____

Date: _____

Consent for Treatment

I, the undersigned, hereby authorize the medical staff of [Hospital Name] to perform necessary medical treatment and diagnostic procedures as deemed necessary in the event of a medical emergency.

I understand that in the case of an emergency, medical treatment may be performed without my prior consent, as the staff will act in the best interest of my health.

I acknowledge that I have had the opportunity to ask questions regarding the procedures and treatments, and that those questions have been answered to my satisfaction.

Signature

Patient or Guardian Name: _____

Signature: _____

Date: _____

If signed by someone other than the patient, please indicate your relationship:

Relationship to Patient: _____