CATHOLIC DIOCESE OF SAGINAW
ADULT MEDICAL TREATMENT AUTHORIZATION

To Whom It May Concern:

I do hereby authorize the treatment by a qualified and licensed physician of any condition which, in the opinion of the physician, is deemed necessary and appropriate.

Name: ____

Reason for which release is intended: ______________________________

Address: ______________________________ City: ____________________

Emergency Phone(s): (____) ____________________ (____) ____________________

Family Physician: ____________________________ Phone: ____________________

Physician Address: ___________________________ City: ____________________

List allergies, medication, contacts, or other pertinent comments:

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Health Insurance Data:

Company: ____________________________ Policy: ____________________

Group: ______________________________ Contract: ____________________

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: ________________ Signed: ______________________________

*** Valid for one year**

(July, 2022)