



Intertribal Treatment Center of Nebraska

Medical Emergency Release of Information

I, _____ Hereby authorize the Intertribal Treatment Center and it's counselors and staff to contact the following person(s) in the event of a medical emergency involving me while I am on the property of this program. This allows the counselors and staff to inform any medical personnel of my name; person to notify listed on this authorization, any existing physical or medical conditions, food and/or medicinal allergies, the name and phone number of any primary physician I have listed at the time of intake. This release serves to facilitate medical emergency care for myself.

EMERGENCY Contact:

Relationship:

Phone:

Secondary Contact:

Relationship:

Phone:

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

This authorization shall expire upon my discharge or upon my written request to revoke at my discretion.