

A NEW LEAF, INC.  
Emergency Medical Care Release



I give permission for A New Leaf, Inc. to take \_\_\_\_\_ to a medical emergency room or hospital in the event of a minor medical emergency. All efforts will be made to first contact the participant's guardian/care provider, but if unsuccessful, we will proceed to the emergency location. If the event is of a serious medical nature, 911 will be called immediately.

Any participant medical information that is needed by the facility providing medical care will be released upon request.

I understand that A New Leaf, Inc. is not responsible for the cost or quality of any emergency medical care provided. A New Leaf, Inc. is only acting out of good faith and has no other responsibilities implied or assumed.

Please Print:

Participant Name: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A New Leaf Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_