

MEDICAL AUTHORIZATION AND RELEASE

(Adult)

I, _____, in the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions any one or more adult members of New Journey Ministries, Inc. d/b/a New Journey Fellowship ("NJF").

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and/or dental services rendered, including emergency medical transportation, rendered to me pursuant to this authorization.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgement may deem advisable.

These authorizations shall remain effective for the duration of the following event: _____ or until December 31st, 2009.

Special Instructions (if any): _____

A duly executed copy of this form shall have the same force and effect as the original.

In consideration of the activity or event the undersigned is participating in, I hereby represent and warrant that I am fully, physically, and medically capable of partaking in same and that accidents and/or injuries caused by other individuals may occur. It is my consent to acknowledge and assume such possibility and I hereby release and forever discharge NJF, its officers, agents, employees, representatives, and any other persons connected with such event or activity from all claims, damages, injuries, medical treatment expenses, and causes of action that may arise from the event or activity.

Dated this ___ day of _____, 200__.

Signature

Witnesses:

Signature

Signature

Printed Name

Print Name

SPECIAL MEDICAL CONDITIONS OR NEEDS:

List any unusual health history or allergies: _____

Date of Last Tetanus Toxoid: ____/____/____

Other medical conditions or needs:

HEALTH CARE PROVIDER INFORMATION:

NAME OF INSURANCE COMPANY: _____
GROUP OR POLICY NUMBER: _____
CLAIMS PHONE NUMBER: _____

EMERGENCY INFORMATION:

Home Address: _____
Father: _____ Phone # Home: _____ Work: _____
Mother: _____ Phone # Home: _____ Work: _____
Legal Guardian: _____ Phone # Home: _____ Work: _____
Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Insurance: _____ Policy Number: _____

STATE OF FLORIDA §
 §
COUNTY OF PINELLAS §

BE IT KNOWN, that on the ____ day of _____, 200__, before me, the undersigned notary in and for the State of Florida, duly commissioned and sworn, dwelling in the county of Pinellas, personally came and appeared _____, to me personally known or who produced valid identification, and being the same person described in and who executed and acknowledged the within medical authorization and release to be his/her act and deed.

Notary Public