8. Medical Emergency Treatment Form

PERMISSION FOR MEDICAL/EMERGENCY TREATMENT

On rare occasions, an emergency requiring hospitalization and/or surgery develops. Since minors may not, as a rule, be administered an anesthetic or be operated upon without the written consent of the parent or guardian, we request that parents or guardians sign the following statement. Every effort will be made to contact the parent or guardian before any major treatment. This form is to prevent a dangerous delay in case an emergency does occur and we are unable to contact parents.

Non-emergency Treatment:

In the event of injury or illness or if missing vaccinations and health examinations are needed for our son/daughter/ward, we

_____, born _____,
(Parents Names, Printed) *(mm/dd/yyyy)*

hereby authorize Pan Atlantic representatives, their offices, and/or agents, to secure whatever is deemed necessary, including the administration of an anesthetic and surgery.

Please note, this form must be signed as is; no changes to the form will be accepted.

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date (mm/dd/yyyy): _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date (mm/dd/yyyy): _____

1 Union Street, Suite 202
Portland, Maine 04101
+1.207.871.8622

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

By completing this form, you give consent to Pan Atlantic Foundation, your parents or guardian, your physicians, and/or other medical providers to discuss your medical and/or insurance issues with Pan Atlantic Foundation. You also consent to Pan Atlantic Foundation utilizing any such material in and as necessary in treating any medical condition which may arise. You also consent that Pan Atlantic Foundation may notify your emergency contact listed in this application of any situation that Pan Atlantic Foundation deems to be an emergency. In addition, you consent that Pan Atlantic Foundation may notify the official Pan Atlantic designated agency from whom you purchased this program of any situation that we deem to be an emergency.

This authorization is valid for two years from the date signed.

I give Pan Atlantic Foundation permission to release any or all of the following information in and as appropriate in the event of a medical condition:

Please check each box.

☐ All financial and claim information related to medical bills or Claimant's Statement and Authorization.

☐ Provider name, date of service, total charge, total paid and date of payment.

☐ Insurance ID number and/or social security number.

Under no circumstances can Pan Atlantic Foundation release medical information from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

Student Name (printed): _____

Student Signature: _____

Date (mm/dd/yyyy): _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date (mm/dd/yyyy): _____

1 Union Street, Suite 202
Portland, Maine 04101
+1.207.871.8622