

MEDICAL AUTHORIZATION

TO: THE ATTENDING PHYSICIAN AND/OR HOSPITAL

I hereby authorize reasonable and necessary medical care, including, but not limited to, any emergency surgical procedure or hospitalization deemed necessary by a qualified and licensed physician for my welfare.

CONSENT TO DISCLOSE MEDICAL INFORMATION

I further authorize Lake Norman Baptist church and its authorized representatives to disclose any health related information to any health care provider.

**I HAVE CAREFULLY READ THIS DOCUMENT AND FULLY UNDERSTAND ITS CONTENTS.**

Date: \_\_\_\_\_

Signature of Participant \_\_\_\_\_

Printed Name of Participant \_\_\_\_\_