Release of Ambulance Transport

PATIENT OR DECISION MAKER

I understand that Beebe Healthcare treatment team is recommending Ambulancetransport from: Beebe Healthcare Lewes to (______________________________) for continued care of______________________(Patients Name). I have been offered ambulance transport but choose to have a family member or friend drive me to the **above address**. I acknowledge that I have been informed of the risk(s) involved.I do hereby release and hold harmless Beebe Healthcare, its employees, agents, and the medical staff, of and from liability which may arise.

______________________ Signature of Patient	______________________ Decision Maker Signature	________ Date	________ Time
______________________ Decision Maker Printed Name	______________________ Relationship to Patient	________ Date	________ Time
______________________ Witness Signature	______________________ Witness Print Name	________ Date	________ Time
______________________ Provider Signature/Credentials	______________________ Print Name or ID #	________ Date	________ Time

DESIGNATED DRIVER

I,______________________agree to drive the patient named above to the above address
(Print Name)

My phone number is (_____)_____-___________

______________________ Signature of Designated Driver	______________________ Relationship to Patient	________ Date	________ Time

Telephone Consent needed if patient has a guardian that is not a direct relative and is not present.

______________________ Name of person Providing Consent	______________________ Relationship to patient if decision maker		
______________________ Witness Signature		________ Date	________ Time
______________________ Witness Signature		________ Date	________ Time

This information has been presented to the ☐ patient ☐ representative in Patient's Preferred Language (specify language)______________________

______________________ Interpreter name	______________________ Agency and ID# (if applicable)

______________________ Witness Signature	______________________ Relationship to Patient	________ Date	________ Time

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