

376 Vallombrosa Avenue
Chico, California 95926
Phone (530) 891-1676
FAX (530) 891-1833
Tax I.D. 68-0311224



5875 Clark Road
Paradise, California 95969
Phone (530) 877-5433
FAX (530) 877-5708
Tax I.D. 68-0311224

**Immediate Care Medical Center
Patient Authorization for Use and Disclosure of Protected Health Information**

This health information is requested from:

Doctor: _____

Address: _____

City & Zip: _____

This health information may be disclosed to:

(name and address of person to use or receive the health information)

This authorization permits ICMC, to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____

Enter Date

I do not have to sign this authorization in order to receive treatment from ICMC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Immediate Care Medical Center, 376 Vallombrosa Ave., Chico, CA 95926.

Signed by _____

Signature of Patient or Legal Guardian

Date

Relationship to patient

By signing, I authorize Immediate Care Medical Center, (ICMC) to use and/or disclose certain protected health information (PHI) about me

Print Patient's name

Patient/guardian must be provided with a signed copy of this authorization form.

Print name of legal guardian if applicable

Released Authorization By _____

Date Released _____

Released By _____