PREMIERE PRIMARY CARE
A division of Immediate Care Medical Center

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Phone (530) 809-0674 ◆ FAX (530) 809-4085
Tax I.D. 68-0311224

# 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 | Print name of legal guardian if applicable

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

_____ Date Released_____
Released Authorization By

Released By _____