



Physicians Immediate Care
CONSENT, ASSIGNMENT, RELEASE FORM

CONSENT FOR MEDICAL TREATMENT-- I voluntarily present for treatment and consent to my physician and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care.

RELEASE AND USE OF PATIENT INFORMATION-- I authorize the release of my medical records, information, treatment and advice, and specific health information to:

- (1) AN EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana)
(2) INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.
(3) EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law
(4) TREATING PHYSICIANS on staff at Physicians Immediate Care, their agents and allied health professionals; to another health care facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care.

I understand this information concerning medical care, advice or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization.. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE—In consideration of services provided by Physicians Immediate Care, I hereby assign and transfer to Physicians Immediate Care any and all rights, which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Physicians Immediate Care to me or to one of my dependents.

I give consent, authorize release, and assign benefits to PIC: Patient/Guarantor signature

RECEIPT OF HIPAA PRIVACY NOTICE—

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Physicians Immediate Care may use and disclose my protected health information. I understand that Physicians Immediate Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Printed Patient Name Date

Signature of Patient or Parent/Guardian

Office use only: (To be completed only when patient declines to sign acknowledgment):
Check here if patient declined to sign acknowledgement Staff initials Date

