FirstCall MEDICAL CENTER
URGENT CARE - LABS - X-RAYS & DIAGNOSTIC

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by FirstCall Urgent Care in order to carry out treatment, payment or health care operations. You should review the Practice's Notice of Privacy Practice for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form. We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from your front desk staff. You retain the right to request that we further restrict how your protected health information is release or used to carry out treatment, payment, or health care operations. Our practice is not requested to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I agree and consent to FirstCall Urgent Care releasing information to me in the following manners:

VIA MAIL **PLEASE INITIAL**

- OK TO MAIL TO HOME ADDRESS _____
- OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

- OK TO LEAVE DETAILED MESSAGE _____
- LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

- OK TO LEAVE DETAILED MESSAGE _____
- LEAVE CALL BACK NUMBER ONLY _____

VIA FAX OK TO FAX TO: _____

By signing below, I attest that the information provided above is true and accurate Signature of Insured/Guardian: _____ Date:_____