Integrity Urgent Care

PATIENT CONSENT FOR TREATMENT AND FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE MEDICAL TREATMENT AS DEEMED NECESSARY AND APPROPRIATE BY THE PHYSICIANS OF INTEGRITY URGENT CARE AND THEIR EMPLOYEES PARTICIPATING IN MY CARE.

With my consent, Integrity Urgent Care, may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment and healthcare operations. Please refer to the Integrity Urgent Care's **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

With my consent, Integrity Urgent Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Integrity Urgent Care may relay any items that assist the practice in carrying out treatment, payment or healthcare operations such as appointment reminders, insurance items, statement reminders and any information pertaining to my clinical care, including laboratory results among others, to:

PLEASE LIST PERSON(S) THAT WE CAN SPEAK WITH ON YOUR BEHALF
(PLEASE LIST BOTH PARENTS OR GUARDIANS FOR MINOR PATIENTS)

Name	Relationship to Patient
Name	Relationship to Patient

With my consent, Integrity Urgent Care may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked.

With my consent, I authorize Integrity Urgent Care to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the patient registration form.

I have the right to request that Integrity Urgent Care restrict how it uses or discloses my PHI to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to Integrity Urgent Care. I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment including those that are considered rejected, co-pay, deductible or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize my physician to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Integrity Urgent Care has the right to decline to provide treatment to me.

By signing this form, I am consenting Integrity Urgent Care's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

Patient/Legal Guardian Signature	Date
Printed Name of Patient/Legal Guardian	Witness