Authorization for Release of Health Information

I, _____ (Name), authorize **iCare Urgent Care Center** to release my health information to _____ (practice/physician/individuals name).

Patient Information

I understand that my treatment will not be conditional upon signing this authorization and that I have the right to refuse to sign this authorization.

I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal state law.

I understand that I have the right to revoke this authorization by sending a written notice to the address of the **iCare Urgent Care Center at 21001 SE 29th, Harrah OK 73045.**

I also understand that a revocation is not effective if the information has already been disclosed but will be affective going forward from date of notice.

I understand that I have the right to inspect or copy the protected health information as described in this document, I can do this in written notification.

Receipt of HIPPA Privacy Notice

iCare Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulation of the health insurance portability and accountability act (HIPPA) have taken affect April 14, 2003. In support of our policy, complying with all applicable regulation iCare Urgent Care Centers provides patients with the HIPPA notice of privacy rights.

While not required in order to receive treatment at iCare Urgent Care Centers, we are obligated under the federal regulation to ask that you sign an acknowledgement of the HIPPA privacy notice and that a copy of the notice will be made available to you.

Patient consent for Treatment

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by iCare Urgent Care Centers and its associated physicians, practitioners, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the result of the treatments or examinations at iCare Urgent Care Centers.
2. I consent to the use and disclosure of my/the patients protected health information for the purpose of obtaining payments for services rendered to me/the patient, treatment and healthcare operations consistent with the iCare Urgent Care Center notice of privacy practices.
3. I authorize payment of medical benefits to iCare Urgent Care Center physicians and their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions of all my medical treatment.

I have received a copy of the notice of privacy practice and financial policy notice: _____ (Initial)

_____ _____
Print Patient's Name Patient DOB

_____ _____
(Patient or Authorized representative signature) (Today's Date)