EXECUTIVE
URGENT CARE
AT INDIAN WELLS

Health Information & Notice of Privacy

I authorize the use and/or disclosure of my protected health information as set forth below:

1. The only protected health information that may be used or disclosed is any information provided by me to my provider, or any information gathered or ascertained by my provider as a result of any physical condition, medical history, or radiological or other medical procedures.

2. The name, or other specific identification, of the person(s) or class of persons authorized to make the use/disclosure of my protected health information: My provider, his medical or technical assistants, and all duly authorized office personnel or staff of the provider.

3. The name, or other specific identification, of the person(s) or class of persons who are authorized to receive my protected health information:

Executive Urgent Care of Indian Wells and its representatives, agents and subcontractors (including but not limited to adjusters and nurses, case managers) of the entity that providers or arranges for applicable workers compensation or other benefits (hereafter, the workers compensation carrier) all duly authorized representative of my employer (or such other party for whom I have rendered services as necessary and appropriate for the review and disposition of any workers compensation or other similar benefits (hereafter the employer).

4. My protected health information will be used and disclosed for the following purposes only (each purpose listed and described):

To Insurance carriers for its use in the provision of certain provider quality assessment services, appropriate payment for professional services rendered to EUCIW, to the workers compensation carrier for purposed of reviewing and assessing a treatment plan and otherwise overseeing the claim and the employees, as necessary for the review and disposition of any workers compensation claims or other similar benefits.

5. This authorization will expire at such time (1) my treatment with the provider is concludes, (2) all payment for such treatment has been appropriately made and accounted for, (3) all quality assessment or other operational use of my health information has been made and (4) all information has been disclosed as appropriate to the workers compensation carrier (or other benefits carriers) and/or my employer

6. I may revoke this authorization in writing at any time by contacting my provider or his/her staff at the following address and telephone number, except to the extent that my provider has taken action in reliance on his authorization:

   74-785 Highway 111, Suite 100
   Indian Wells, CA 92210
   Phone 760 346-3932 Fax 760 346-8584

7. I understand that I may refuse to sign this authorization. If I refuse to sign I understand that my provider will not condition my treatment, payment, and/or enrollment in a health plan or eligibility for benefits (if applicable) or whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclose to a third party.

8. I understand that here is a potential for information used or disclosed pursuant to this authorization to be disclosed by the recipient of the information and to no longer be protected by federal or state law.

I hereby certify that I have read the provision set forth in this authorization and understand and agree to its terms.

_____ _____

Patients Signature Date