AUTHORIZATIONS

Consent For Evaluation And Treatment

I hereby authorize Premium Medical Care and/or affiliate, their physicians, employed and/or agents, together with any laboratory designated by Premium Medical Care or any of it's affiliates to perform a physical examination and/or any medical treatment deemed necessary by treating physicians. This includes, but is not limited to, any required medical examinations, x-rays, medical procedures and medical diagnostic or laboratory tests ordered by the physicians(s) to be carried out by the designated employee.

Release of Information

I hereby authorize Premium Medical Care and/or it's affiliates to disclose to my employer, prospective employer, insurance company and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. I authorize the center to release any appropriate information concerning my medical history, examination, treatments, or other diagnostic procedures, including copies of my records to official requesters, including but not limited to insurance companies, third party administrators, or utilization review organizations, healthcare service plans, or to any other person or entity as nec4ssary in connection with certification, payment, or reimbursement for services rendered. I acknowledge that such information may be released pursuant to the following paragraph.

Confidentiality

It is the policy of Premium Medical Care and it's affiliated to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand that medical records may be periodically reviewed by national accreditation or certification surveyors, and other necessary quality assurance personnel and I authorize such release of information. I acknowledge that my records and associated documentation may be disclosed to third parties, including government agencies, as required by law, including, but not limited to, pursuant to a warrant, subpoena, or court order, and I hereby agree not to pursue any action against Premium Medical Care and it's affiliates for any damage I may suffer of such disclosure.

Assignment Of Benefits (Not applicable to Worker's Compensation)

I understand that I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made to me within thirty (30) days from the date Premium Medical Care and/or it's affiliate(s) becomes aware of my insurance ineligibility. Should the account be referred for collection, the undersigned shall pay the collection expenses incurred by Premium Medical Care, and/or it's affiliate, including, without limitation, court costs and attorney fees.

By signing this authorization form I acknowledge that I fully read or had this form read and/or explained to me and that I fully understand its contents. I have been given ample opportunity to ask questions, and that any questions have been answered satisfactorily.

_____ _____

Patient/Legal Representative Name Patient Signature

_____ _____

Witness Date