1387 East 2nd street
Benicia,CA 94510
Phone: (707)377-1005
Fax: (833)992-2353

AUTHORIZATION FOR TREATMENT

Employer Information

Company Name: _____ Fax: _____

Contact Person: _____ Phone: _____ Ext: _____

Employee Information

Last Name: _____ First Name: _____ Occupation: _____

Injury Description: _____

_____

Date of Injury: _____/____/____ Time of Injury: _____ am/pm Place of injury: _____

_____

PLEASE SIGN & FAX TO URGENT CARE AND TELEHEALTH CENTER AT Fax: (833)992-2353
I understand, assign directly to URGENT CARE AND TELEHEALTH, all procedures and medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize URGENT CARE AND TELEHEALTH render services to the above named employee.

Supervisor - Print Name: _____

Supervisor - Signature: _____DATE _____