



2360 First Street  
Napa, CA 94559  
Phone: (707) 377-1007  
Fax: (833) 992-2082

## 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)992-2082**

I understand, assign directly to URGENTCARE 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 URGENTCARE AND TELEHEALTH to render services to the above named employee.

Supervisor - Print Name: \_\_\_\_\_

Supervisor - Signature: \_\_\_\_\_ DATE \_\_\_\_\_