314 Highway 3162
Cut Off, LA 70433
Phone: (985) 632-1820 Fax: (985) 632-1824

CONSENT FOR SERVICES & REPORTING
OCCUPATIONAL MEDICINE

Name: ____DOB: _______________ Sex: _________Race: ______________

Address: ______________________________________City:______________________State: __________Zip:________

SSN: ____________________ Home Number: (____) ___________________ Cell Number: (____) ____________________

COMPANY NAME: ________________________________COMPANY PHONE NUMBER: (____) __________________

Consent for Treatment / Use and Disclosure of Protected Health Information / Financial Obligation

I hereby consent to medical evaluation, testing, and/or treatment provided by the staff of this medical facility. I understand the benefits, risk and possible side effects of receiving medications and vaccines and that it is my responsibility to provide any information relevant to health history, possible medication interactions and allergies. I understand that the provider may use photographs of my injury, wound, etc. for treatment consultation or specialist referrals.

I acknowledge that health care services are being provided to me for the purpose of providing information to my employer, the above specified requestor. I understand that services may be denied if I do not authorize the release of information related to such health care services to the employer who contracted the services.

If drug and/or alcohol testing is required by my employer, I consent to said testing and understand that results will be released to the designated employer representative. Results of said testing may be used to determine my fitness for employment or continued employment with the above specified requesting company.

I acknowledge that if I am claiming a work-related injury, I must notify my employer of this injury and provide necessary information to my employer to file a worker's compensations claim for the accident. A claim must be filed and approved in order for medical benefits to be paid. If my injury is ruled NOT work-related, or I fail to follow the required procedures for making a claim, I will be responsible for the payment of my bill for all medical services provided.

I give my specific authorization that the company may use or disclose my Protected Health Information (PHI) necessary to carry out treatment and testing and reporting as required and requested by my employer, as specified above. This authorization is valid for 6 months from the date signed and may be revoked at any time per the Written Specific Request to Exercise My Patient Rights form. I understand that revocation will not pertain to information that has already been released and revoking the authorization may affect my continued employment with the above specified requestor. I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by the specified requesting company and then no longer be protected by HIPAA.

Information Requested □ All Dates of Service □ Specific Date of Service: ________ to _________

□ Complete Health Record □ History/Physical Exam □ Progress Notes □ Consultation Reports □ Work Status Reports

□ Laboratory Test Reports □ Drug/Alcohol Test Reports □ EKG Reports □ Radiology Reports □ Complete Billing Record

□ HIV Testing □ Chemical Dependency □ Other ____________________

I acknowledge that I have been provided access to the Notice of Privacy Practices and Patient Rights and Responsibilities and have had the opportunity to ask questions, file a complaint to have concerns addressed, and/or submit special written request.

As the employee I have certain rights to access, inspect, copy, and control the use and disclosure of the information contained within my health records. This authorization requirement does not apply to Public Health Reporting or Workers Comp reporting (those are allowable and covered under HIPAA to release without patient authorization).

Signature: ____ Date: _____/_____/______

Witness/Relationship to Patient: ____