OCCUPATIONAL HEALTH CENTER

Consent for Treatment and Release of Information

Last Name: ______________________ First Name: ______________ M.I.: ____

Home Address: ______________________ City/State/Zip: ______________

Sex: ________ Date of Birth: ______________ SSN: ______________

Cell Phone: ______________________ Home Phone: ______________

Employer: ____

I AUTHORIZE the Occupational Health Center (OHC) to provide medical treatment and to perform medical evaluations including but not limited to urine, hair or breath samples to screen for the presence of drugs, alcohol and other chemical substances as requested or required by my current or prospective employer.

I CONSENT to OHC's use and disclosure of all individually identifiable personal, health, financial and demographic information (known as Protected Health Information or PHI) for purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- Providing results from my physical evaluations and other diagnostic tests regardless of result to my employer or prospective employer
- In addition, doing all other things directly related to providing healthcare to me (messages, reminders)
- If using private insurance, please note that you may be sent a bill for services not covered if deductibles/copays have not been met. These bills need to be paid promptly to OHC to avoid any further collection actions.

The above purposes and all other uses are known collectively as Treatment, Payment and Other Healthcare Operations or TPO and this information may include or be related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infection or pregnancy. You may review or receive a copy of our entire Notice of Privacy Practices upon request.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to OHC when needed for the purpose of TPO.

I CONSENT to OHC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, human immunodeficiency virus (HIV), HIV-related opportunistic infections or pregnancy with the following personal contact(s)

1. ______________________________ Relationship: ______________
2. ______________________________ Relationship: ______________

I have been given the opportunity to review and agree with the terms and conditions of OHC's Patient Information Protection Plan. I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I chose not to consent to the terms and conditions of OHC's Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

PATIENT'S SIGNATURE: ______________________________ DATE: __________

GUARDIAN'S SIGNATURE: ______________________________ DATE: __________

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protected health information for non-healthcare related activities without specific and explicit authorization.