Northwest Health – Occupational Medicine

Patient Registration

Employer Paying for Services: _____

Patient's First Name: _____ Last Name: _____ M.I.: ___

DOB: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female SSN:_____-_____-_____

Patient Address: _____ City: _____ State: ___ Zip Code: _____

Patient Home Ph: (_____) _____-_____ Patient Cell Ph: (_____) _____-_____

General Consent for Treatment and Release of Information

I authorize the physicians, their associates, and employees of Workforce Health to examine, diagnose, and treat my injury and/ or conduct employment-related testing/ screenings as requested for employment purposes.

I authorize NW Health – Occupational Medicine to disclose the information listed within this authorization to the company listed above. In the case of a work-related injury, I also understand that this clinic and/ or my employer may be sharing information related to this injury with my employer's workers' compensation insurance carrier.

The purpose of this disclosure is: Reimbursement, Medical Care, and Employer Requirements.

The information to be disclosed is: All medical records including, but not limited to: Physician's progress notes, Diagnostic imaging reports, Drug/ Alcohol testing results.

This authorization to disclose the above-listed information expires in sixty (60) days unless a shorter time period is specified on this authorization.

I understand that I may revoke this authorization at any time before the information has been used or disclosed. I must revoke this authorization in writing and submit the written revocation to the Office Manager (Refer to NW Health – Occupational Medicine Notice of Privacy Practices for further information).

Information used or disclosed according to this signed authorization may be re-disclosed by the agency or person receiving this information and may no longer be protected by the HIPAA privacy regulations.

I consent that I have read, understand, and authorize the consent for medical services and the release of any required medical information.

_____ _____

Signature of Patient/ Legal Guardian/ Power of Attorney Date

_____ _____

Signature of Witness Date

Acknowledgement of Receipt of Workforce Health Notice of Privacy Practices

By my signature below, I acknowledge the following: (check which applies):

☐ I have received the NW Health – Occupational Medicine Notice of Privacy Practices.

☐ I have been offered and declined to receive the NW Health – Occupational Medicine Notice of Privacy Practices. I understand that I may request a copy of the Notice at any time and that Workforce Health and its medical staff will use and disclose my information as outlined in the Notice of Privacy Practices without my signed acknowledgement of receipt of this Notice.

☐ Patient refuses to sign – staff initials below.

Printed Patient Name: _____

Signed: _____ Date: _____ NW Health – Occupational Medicine Staff initials: _____

Relationship to patient if not signed by patient: _____