

**Occupational Health Center, LLC**

1245 E. Spring St. Suite G Cookeville, TN 38501 \* Phone (931) 526.1604 \* Fax: (931) 526.7378

**OCCUPATIONAL MEDICINE REGISTRATION FORM**

*(Please Print)*

**PATIENT INFORMATION:**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for today's visit: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**EMPLOYER INFORMATION:**

Company Name: \_\_\_\_\_ Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Supervisor/Manager to Authorize Treatment: \_\_\_\_\_ Authorized: Yes / No  
 Mailing Address: \_\_\_\_\_ *(Office Use Only)*  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CONSENT FOR INJURY / PHYSICAL TREATMENT:**

I hereby consent to a medical history and physical examination and/or receive treatment by this Physician, his assistant, or any designee of Occupational Health Center. I authorize Occupational Health Center to release my employer, my employer's agent and/or my employer's insurance carrier any and all information contained in my medical records through any assessment, examination, diagnosis, or treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR SUBSTANCE TESTING:**

I consent to the taking of specimen for drug and/or alcohol screening as a part of this examination and authorize the release of those results to my employer, my employer's MRO and/or any other agent or designee of my employer. I understand that the test specimen(s), information obtained and records created as a result of this test are also the sole property of Occupational Health Center and waive any claim to the same.

I understand that the taking of a urine sample may be done in the presence of a witness and hereby consent to the presence of a witness. I also understand certain risks are present with an invasive procedure such as drawing blood. Should this be a method of sample collection, it would not be uncommon to experience minor or temporary reactions, including a slight bruise, swelling or local infection where the needle pierces the skin. Other non-serious reactions may include headache, or a feeling of light-headedness or dizziness. I affirm that I do not have hemophilia or a heart condition, and that I am not using any anticoagulant drugs.

I hereby certify that the above risks have been explained to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE:**

I understand that the results of the medical history, physical examination, treatment, assessment, diagnosis and/or substance testing may affect my employment status and/or claim. I knowingly and voluntarily release Occupational Health Center, any physician, assistant, employee, or any designee of Occupational Health Center involved in taking, witnessing or testing of any sample, the taking or recording of a medical history, conducting a physical examination, assessment or diagnosis, and/or providing treatment from all claims and liability associated with, arise out of, or otherwise related to the release of any information as authorized herein and/or any adverse employment action and/or adverse decision regarding any claim as a result of the services provided by Occupational Health Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Name:  
Date:  
Social:

Occupational Health Center, LLC  
1245 East Spring St. Suite G Cookeville, TN 38501  
(phone) 931-526-1604 (fax) 931-526-7378

### Authorization for Use and Disclosure of Protected Health Insurance (PHI)

When signed, this will authorize Occupational Health Center, LLC to use and disclose certain Protected Health Information (PHI) about me. I realize that this information is voluntary, and that I may refuse to sign.

- I. I hereby authorize Occupational Health Center, LLC (OHC) to disclose PHI relating me:
- a. Name \_\_\_\_\_
  - b. Date of Birth \_\_\_\_\_
  - c. Purpose of Disclosure is Medical Care, unless otherwise noted below  
 other \_\_\_\_\_
  - d. Information to be disclosed is  
Entire Health Record unless otherwise noted below  
 other \_\_\_\_\_
  - e. Information NOT to be disclosed is  
 AIDS or HIV status  
(Acquired Immune Deficiency Syndrome/Human Immunodeficiency Virus)  
 Treatment for drug or alcohol abuse  
 Mental or Behavioral Health or Psychiatric care
- II. The persons authorized to disclose this information are the employees of Occupational Health Center, LLC (OHC)
- III. The persons authorized to receive this information are \_\_\_\_\_
- IV. I acknowledge the following statements:
- a. I acknowledge that I may revoke this authorization at any time by notifying OHC in writing of my intent to revoke this authorization. My notification must be addressed to:  
Occupational Health Center, LLC; Attn: Medical Records  
1245 East Spring St. Suite G; Cookeville, TN 38501  
If I do notify OHC in writing and revoke this authorization, that revocation will NOT have any effect on any actions already taken by OHC prior to the revocation. Initials \_\_\_\_\_
  - b. Unless otherwise revoked, this authorization will expire 1 year from the date this form signed. Initials \_\_\_\_\_
  - c. I understand that the information disclosed because of this authorization may be subject to redisclosure by the recipient because it may no longer be protected by U.S. Federal privacy regulations. Initials \_\_\_\_\_
  - d. I understand that I may inspect and obtain a copy of the information to be disclosed before I sign this form, if I ask to do so. Initials \_\_\_\_\_
  - e. I understand that OHC will give me a copy of the authorization form, if I wish to have one, after I sign it. Initials \_\_\_\_\_
  - f. I understand that, if I submit to a drug and/or alcohol test, an evaluation and/or treatment of an actual or potential work related injury under Workers' Compensation, or an employer/potential employer funded medical evaluation, that my health information is NOT protected, and MUST BE released to my employer/potential employer, and/or the Workers' Compensation insurance carrier. Initials \_\_\_\_\_
  - g. I understand that my PHI may be released to other physicians I identify, either in writing or verbally, as involved in my health care. Initials \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_