# CONSENT FOR SERVICE & REPORTING

Name: ________________________________________________ Age: ___________ Sex: _____________

Address: _______________________________________ City: ____________________ ST_________ ZIP________

Date of Birth: ___________________ SSN_______-_____-_______ Race: _____________ Marital Status: S M W D

Home Number (________) __________________________ Cell Number (________) ___________________________

COMPANY NAME___________________________ COMPANY PHONE NUMBER (____) ______________________

**Consent for Services**

I hereby consent to medical evaluation, testing, and/or treatment provided to me by the Company. 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 company.

**Consent for Use and/or Disclosure of Protected Health Information**

I understand that the Company may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. Any other use or disclosure will require a separate Authorization form. I hereby release the Company and its employees from any liability arising from such disclosure. I understand that my treatment or service may be denied by refusal to sign this consent.

**Authority to Release Protected Health Information**

I hereby authorize the Company to release the information identified in this authorization form from my medical records and provide such information to the company listed above.

**Information to Be Released – Covering the Periods of Health Care** From _________________ To ______________

| | | |
|---|---|---|
| ☐ Complete health record | ☐ Drug/Alcohol test results | ☐ X-ray reports, films, images |
| ☐ History and physical exam | ☐ Diagnosis & treatment codes | ☐ Complete billing record |
| ☐ Laboratory test results | ☐ Consultation reports | ☐ Work status reports |

**Right to Revoke Authorization**

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to the Administrative Office at 10319 Jefferson Hwy, Baton Rouge, LA 70809. Unless revoked, this authorization will expire on the following date 6 months after the date this form was signed.

**Re-Disclosure**

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

**Signature of Patient or Personal Representative Who May Request Disclosure**

If health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed.

**Acknowledgement of Receipt of Privacy Practice Notice**

I hereby acknowledge that I have been given a copy of Company's Notice of Privacy Practices.

_______________________________________________ ________________________________

Signature Date

Description of relationship if not patient: ____________________________________________________