Quad City & Clinton
Occupational
Health

Patient's Last Name First Initial	Age	Sex	Today's Date
Street Address City State Zip	Home Phone #		Cell Phone #
Social Security # or Employee ID # (circle which one applies)	Birthdate		Employer Name

Please indicate marital status (circle): M S D W
Please indicate race (circle): White African American Hispanic Asian Native American Other
Country of Origin:_____ What is your primary Language_____
Do you need interpreter services? _____No _____ Yes

STATE OF CLAIM (circle): Iowa Illinois **DATE OF INJURY**: _____

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I, _____ **(name)** hereby authorize and consent for treatment at Quad City Occupational Health Clinic (QCOH). I also authorize this same facility to release any information acquired in the course of my examination, physical or drug screen to my employer (as noted above) or their designated representative and/or their workers' compensation insurance carrier. This information may be communicated in written or verbal format and may include discussion of treatment plan. This information may be relayed via paper or electronic forms and may be delivered via pickup, fax, mail, secure email or secure portal.
I understand that the information is being disclosed and may be used for legal and/or litigation purposes relating to claims and/or suits related to this **specific injury/physical exam**_____ (date) (including but not limited to physical exams or evaluation.) I understand I have the right to inspect the disclosed information and may revoke my authorization. If I revoke this authorization I will do so in WRITING and it will take effect the day the revocation is received by QCOH. EXCEPTIONS include authorizations that have already been acted upon.
I further release the following **protected information** (PHI):
Please initial the blanks below that you specifically wish to deny release of:
_____**Substance Abuse (Drug or Alcohol) Information** from all health care providers, facilities, and/or obtained by QCOH in the course of my evaluation, care, and treatment.
_____**Mental Health Information** from all health care providers, facilities, and/or obtained by QCOH in the course of my evaluation, care or treatment.
_____ **HIV or AIDS related information**, diagnosis and test results from all health care providers, facilities, and/or in the course of my evaluation, care or treatment.

This **authorization** will expire at the end of care and treatment for the above injury date. If I have had a physical or work evaluation for whatever purpose this authorization will expire 90 days from the date signed below.

Signed: _____ Date: _____

Signature of Parent/ Guardian _____ Date: _____
(If patient is under the age of 18)

I recognize and accept personal responsibility for all fee's incurred at the clinic which are not covered by my employer.

Signed: _____Date:_____

Signature of Parent/ Guardian: _____ Date: _____
(If patient is under the age of 18)

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. The entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of you personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose you're Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:__________________________ Signature:_________________________ Date:________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank You for being one of our valued patients.