Intermountain℠ WorkMed

AT_____

CONSENT FOR SERVICES

(To Be Completed By All Injury Patients, With Or Without A NON-DOT Breath/Urine Test)

Client ID (SSN): _____ Last Name: _____ First Name: _____ MI:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Birth Date: _____ Gender: ❑ Male ❑ Female

Company:_____ Department: _____

Work Phone:_____ Ext:_____ Supervisor: _____

Driver's License # _____ Class: A B C D State _____ Expiration _____

What is your preferred language? _____ Do you request interpretation services? ❑ Yes ❑ No

INJURY INFORMATION:

Date of Injury: _____ Time of Injury: _____ What part of your body was injured: _____

Please describe how the injury occurred: _____

_____

Did another doctor or hospital treat you for this injury? ❑ Yes ❑ No If yes, by whom:_____

X-rays taken: ❑ Yes ❑ No When was your last tetanus shot?_____

Please list allergies to medications and explain symptoms:_____

Do you have any barriers to learning about your medical condition: ❑ No ❑ Yes: _____ (Example: Education, Culture, Language)

How would you like to receive information about your condition (check all that apply) ❑ Written ❑ Verbal ❑ Pictures ❑ Other:_____

CONSENT AND RESPONSIBILITY:

✓ **Consent for Services:** I hereby give consent for Intermountain WorkMed, its contractors, medical staff, and employees to provide facility and other health care services to me and to administer physician orders for my benefit. If I came to WorkMed as the result of an injury, I understand that there is a risk of substantial and serious harm involved in treatment, and I accept such risk in the hope of obtaining beneficial results from such services. No promise of any particular outcome or successful result have been made to me, it being understood and accepted that there is some uncertainty involved in the services for which this consent is given. All questions about the treatment and services have been answered to my satisfaction. If I desire further information about my condition or treatment, I understand that I can and should ask additional questions.

✓ **Release of Information:** I understand that the law requires Intermountain WorkMed to make and keep records of my medical treatment. Intermountain WorkMed safeguards those records and it uses and discloses such records and the information they contain only in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in INTERMOUNTAIN's Notice of Privacy Practices, which may be amended from time to time. I understand that I may ask to see a copy of the current notice at any time.

____ **NON-DOT Drug and Alcohol Testing at Intermountain WorkMed:** If I am here for a drug or alcohol test, I hereby authorize Intermountain WorkMed to release my specimen to an independent forensic toxicology laboratory designated by my employer/potential employer. I understand that the laboratory will perform tests for drugs and/or alcohol on samples of my urine, blood, or hair. I further authorize release of the test results to the designated representatives of my employer/potential employer. If requested, I agree to sign a separate Authorization to release the information. If applicable, I understand that Intermountain WorkMed follows manufacturer recommendations for the conduct and interpretation of Rapid Drug Screens and verifies each non-negative result with a certified laboratory before reporting the test as positive. I understand and agree that Intermountain WorkMed is not responsible for the work of any independent lab that may perform such tests. I agree that Intermountain WorkMed is not responsible for any actions my employer/potential employer may take or not take as the result of receiving the results of any test. I agree to notify Intermountain WorkMed of any information that I consider relevant to the test, including identification of currently or recently used prescription or nonprescription drugs, or other relevant medical information. I understand that I will not have a physician – patient relationship with Intermountain WorkMed as the result of the test and that Intermountain WorkMed will not release the results of the test to me.

Responsibility: I understand that if I am here for an injury and workers compensation is denied for any reason, I am financially responsible for charges incurred in connection with all visits related to the injury, including costs, expenses, and reasonable attorney's fees if this matter is placed for collection.

I acknowledge that I have been offered or received a copy of the current Intermountain Healthcare Notice of Privacy Practices.

Signature:_____ **Date:**_____

NPP Given:_____ ❑ Photo ID Verified Collector Initials: _____

Intermountain℠ WorkMed

Authorization for Intermountain WorkMed to Disclose Protected Health Information

(To be completed by injury patients, recipients of exams and non-DOT breath/urine test donors)

Authorization to release the health information of:	
Name	Date of Birth

This authorization is to release health information to:			
Company Name		Phone	
Address	City	State	Zip

The purpose of this disclosure is (check all that apply)

❑ Employers request ❑ Employment related physical and/or work capacity determination ❑ NON-DOT Drug/Alcohol Test ❑ OSHA

Dates of service - (Today and/or Other Dates):

Release the following information (check all that apply)

❑	❑	❑
NON-DOT Drug/Alcohol Specimen(s) and/or Reports	OSHA Information	Medical treatment report including physical examination, medical history and work capacity.

This Authorization will remain in effect until _____

Unless otherwise noted above this authorization will remain in effect 180 days from the date signed (whichever is sooner)

I understand that:

- Once Intermountain WorkMed discloses my health information by my request, it cannot guarantee that the Company mentioned above will not re-disclose my health information to a third party. The Company may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I may make a request in writing at any time to Intermountain WorkMed to inspect and/or obtain a copy of my health information maintained at this facility (as provided in the Federal Privacy Rule 45 CFR §164.524).
- This Authorization will remain in effect until the Authorization expires as stated above, or until I provide a written notice of revocation to Intermountain WorkMed.
- I may refuse to sign this, but if I do, Intermountain WorkMed may not be able to provide the service, or Intermountain WorkMed may be required to report my refusal to my employer.
- I may change my mind in the future and ask Intermountain WorkMed not to send this information, if they have not already sent it; to do so I must provide a written request of revocation to Intermountain WorkMed. However, if I do, I may be required to pay for Intermountain WorkMed services, or, if this service was provided as a condition of my employment, my employer may take action regarding my employment as a result.

If I have questions about disclosure of my health information, I can contact Intermountain WorkMed at (801)442-3829

Signature of Patient or Legal Representative _____ Date _____

If Signed by Legal Representative, Relationship to Patient _____