

**Please Print Clearly**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ DL # or other ID: \_\_\_\_\_

Employer/Potential Employer/Temp Agency: \_\_\_\_\_

**By signing below, I acknowledge the following:**

- 1) I hereby give authorization to SSM WorkHealth to provide me with medical treatment for my work-related injury/illness and/or employment-related physical examination. I understand that employment-related physical examinations are not meant to replace routine health care as provided by my private physician. I also understand that an employment-related examination is often times not a complete evaluation and is being performed solely to evaluate my ability to safely perform the tasks required of me by the job I am applying for or the job I am currently performing.
- 2) I hereby give SSM WorkHealth authorization to release to my employer, insurance company, and their representatives any medical information which is obtained as part of the treatment for this work related injury/illness, or employment-related physical examination.
- 3) I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- 4) I understand that I may revoke this authorization at any time, except to the extent that action has been taken by SSM WorkHealth, by providing a written request to the Office where my care was provided.
- 5) I understand that I am not required to sign this form and medical treatment and/or substance abuse testing will not be withheld as a condition of signing this form.
- 6) I have been provided the SSM WorkHealth Notice of Privacy Practices.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Substance Abuse Testing****If you are here for substance abuse testing at the request of your employer or prospective employer, the results will be sent to the designated employer representative (DER) at the above-mentioned company.**Type of Test:  Urine Drug Test  Breath Alcohol  Other \_\_\_\_\_Reason for testing:  Pre-employment  Random  Post Accident  Reasonable Suspicion  
 Return to Duty  Follow Up  Other \_\_\_\_\_**I understand that refusal or failure to submit to the requested test(s) at this time may be viewed as a positive test result or as described in your company policy. I understand that I may not leave the clinic unless given permission or have completed the collection/testing process.** I have read and understand the above mentioned paragraph.**Office Use Only (Write Comments on Back of Form)**

Substance Abuse Test completed (Collector's Initials): Without incident \_\_\_\_\_ With Incident \_\_\_\_\_ (See Comments)