OccuHealth @ N.W.O.

Patient Summary

Patient Information (Please print clearly and use ink pen)			
Last Name:	**First Name:**	**Middle Name:**	**Date of Birth (mm-dd-yyy):**
SSN:	**Sex:** M ☐ F ☐	**Status:** Married Single Widowed Divorced	
Address:	**City:**	**State:**	**Zip:**
Home Telephone:	**Cell Phone:**		
Employer:			
If Minor Child, Parent/Guardian Name & DOB:			

I hereby authorize N.W.O. Health Partners LLC / OccuHealth to perform and examination and/or testing. I also authorize the release of these results, and the release of future tests, service or exams done in connection with this exam to my employer. Test results will be release to your primary care physician per your request and authorization.

Examinee:_____ Date:_____

Authorization for Release of Medical Information

Description of the information to be disclosed:

_____ History and Physical exams (Includes DOT) _____ Other

Purpose of this request:

_____ At the request of the Employer _____ At the request of the patient

Name and address of tht facility (Employer) to receive health information:

Name: _____

Address/City/State/Zip: _____

Expiration of Authorization: This authorization expires _____ (enter date or event). Unless otherwise noted, this authorization will expire 12 months after the date of the signature on this form.

1. I understand that the information in my health record may include information relating to sexually transmitted disease, tuberculosis (TB), hepatitis B, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that if the person or entity that receives the above information is not a health care provider or health care plan covered by federal privacy regulations, the information described above could be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, except in the instance of research-related treatment or when the provision of health care to me is solely for the purpose of creating protected health information for disclosure to a third party.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to NWO Health Partners, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.
5. In accordance with State law, unless otherwise revoked, for Ohio entities this authorization will expire in 1 year. If this authorization is for a use or disclosure of PHI for research, this authorization will expire at the end of the research study.

_____ _____

Signature of Patient or Patient Representative **Date**

_____ _____

Printed Name **Relationship/Authorization (if other than Patient)**