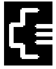 *Inova Occupational Health*

REGISTRATION FORM - OCCUPATIONAL HEALTH

PLEASE COMPLETE THE FOLLOWING INFORMATION
(PLEASE PRINT CLEARLY AND LEGIBLY)

PATIENT LAST NAME:_______________________________________**FIRST:**___________________**MI:**______

MAIDEN NAME:_________________________________ **SS # or ID #:**__________-______-___________

ADDRESS ____**APT #:**____________

ZIP:___________________ **CITY:**_________________________________ **STATE:**____________________

PHONE: HOME: (_____)__________________**DATE OF BIRTH** ____/_____/_____ **AGE:**______ **SEX: M / F**

EMPLOYMENT STATUS : FULL TIME / PART TIME **MARITAL STATUS:** ______________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Inova Occupational Health to release the following information to:

___________________________________**or the agent designated in their contract with Inova Occupational Health.**
NAME OF EMPLOYER

_____________________________________ ____________________ ______ _________ (___)____________
STREET ADDRESS **CITY** **STATE** **ZIP** **PHONE**

Information to be released / disclosed:

- ____**Audiometry results**
- ____**Drug and alcohol test results**
- ____**Health history / Physical exam**
- ____**Lab / EKG**
- ____**Medical clearance form**
- ____**Pulmonary function test**
- _____**Tuberculosis screening / vaccinations**
- _____**Stress test**
- _____**X-ray films / x-ray reports**
- _____**Respirator medical clearance**
- _____**Other:** ___________________________
  ____

I understand that if the person or agency that receives information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

NOTIFICATION OF RESPONSIBILITY

In the event my workers' compensation claim is denied by my carrier, I agree to be responsible for the cost of this visit and any further care related to this visit, and additional costs associated with enforcing this agreement, including collection costs and reasonable attorney fees.

_______________________________________ _______________________________________
SIGNATURE OF PATIENT or REPRESENTATIVE **DATE (Authorization will expire in 6 months)**

____
If Representative, Print Name and Relationship to Patient