Consent for Treatment and Authorization for Release of Records

Consent for Treatment

I consent to the treatment, physical examination or testing performed by the healthcare providers and professional staff at St. Luke's Workplace Health. I understand that the individuals caring for me will provide treatment that they judge to be beneficial to me, or has been requested by my employer or prospective employer. I understand that this care may include tests, examinations, x-rays, and the drawing of my blood, and other diagnostic or therapeutic procedures.

I understand that I may be instructed to contact a physician or return to St. Luke's Workplace Health for continued and complete medical diagnosis and care or follow up treatment. I understand that if a referral is needed, St. Luke's Workplace Health staff will refer me to physicians within network or as directed by my employer/insurance carrier.

I understand that I must promptly notify my employer if I feel my injury is work-related and provide the necessary information for my employer to file a workers' compensation claim. A claim must be filed and approved in order for medical benefits to be paid. I understand that if my injury is ruled NOT work-related, or I fail to follow the required procedures for making a claim, I will be responsible for payment of the bill for all medical services provided.

I acknowledge that a listing of Patient Rights as well as a copy of St. Luke's Notice of Privacy Practices has been made available to me.

Acknowledgement of Release of Records

I hereby acknowledge that St. Luke's Workplace Health will release any and all medical information, test results, evaluations and medical documentation concerning me to my employer, to the workers' compensation and labor and industrial relations agencies in the state in which I have filed a claim for compensation, my employer's workers' compensation insurance carrier, to any other entity, person, or business which may require such documentation to determine claim or benefit eligibility, or any physician or health care facility with which I have established a treatment relationship or who will need my records for my continued treatment. I also acknowledge that the results of any tests or evaluations required by my employer will be released to my employer. My employer is

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Signature ____________________________________ Date ______________ Time ______________

Patient ID: Date of Birth:

Staff Signature ____________________________________ Date ______________ Time ______________