MEDCARE OCCUPATIONAL HEALTH

31047 State Highway 100 · Los Fresnos, TX 78566
+1 956-233-2103 · medcareocc@gmail.com

PATIENT ID / RECORD # _____

Consent / Authorization for Disclosure of PHI

FORM MC-101

PURSUANT TO 45 CFR 164.508

PATIENT IDENTIFICATION

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

ADDRESS | CITY | STATE | ZIP

CELL / HOME PHONE | WORK PHONE | EMAIL

AUTHORIZATION

I HEREBY AUTHORIZE (CLINIC NAME)

CLINIC ADDRESS

to disclose medical information and/or protected health information (PHI) of the patient listed above to:

MedCare Occupational Health PLLC
31047 State Highway 100, Los Fresnos, TX 78566 · Phone +1 956-233-2103 · medcareocc@gmail.com

PURPOSE Evaluation requested by employer or prospective employer.

TREATMENT DATE(S) FROM | THROUGH

THIS AUTHORIZATION EXPIRES UPON THE FOLLOWING DATE OR EVENT

ACKNOWLEDGEMENTS

- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 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 the Custodian of Records of the above facility. 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 when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I specifically authorize written, oral and telefax communications with MedCare Occupational Health.
- I understand and agree that the results will be disclosed to my Company's representative and/or Medical Review Officer and hereby release MedCare Occupational Health, any employees and/or agents thereof from any and all claims or causes of actions resulting from the disclosure of these results. Additionally, in accordance with Federal Regulations, the Medical Review Officer is authorized to verify medical information supplied by me under the Department of Health and Human Services Mandatory Guidelines for Federal Workplace Drug Testing Programs (this information may include medical records from a hospital, my personal physician, dentist, or pharmacy records).

_____ INITIAL I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and/or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE _____ DATE _____