Urgent Care of the Palm Beaches

Employee Authorization for Occupational Services
Non-Workman's Compensation

To be Submitted by Employer and Signed by Employee & Authorizing Employer

Company Name: ____________________ **Expiration Date** (Do not accept after this date)**:** ____________

Authorized Individual: ________________________ **Company Contact Number:** _________________

Employee (Patient) Name: __________________________ **DOB:** ___________ **SSN:** _______________

☐ Is this an Occupational Medicine Visit? Complete this section for a non-Workers Comp related visit:		
☐ Work Physical	☐ Flu Vaccine	☐ MMR Titer
☐ DOT Physical	☐ MMR Vaccine	☐ Varicella Titer
☐ PPD/TB Skin Test	☐ Pneumococcal Vaccine	☐ Chest X-ray (if positive PPD)
☐ 2 Step PPD	☐ Varicella Vaccine	☐ Quantiferon TB Gold Test

☐ **Drug Screen:**
☐ **Collection Only** ☐**5 Panel** ☐**7 Panel** ☐**10 Panel** ☐**DOT Federal**

Reason for Test:
☐ **Pre-Employment** ☐ **Random** ☐ **Reasonable Suspicion/Cause** ☐ **Post-Accident**
☐ **Return to Duty** ☐ **Follow- Up** ☐ **Other (specify)**

☐ **Any additional services requested including titers, vaccinations, and etc., please note here:**

Employer Authorization: I authorize the above services and understand that my company will be responsible for payment of all authorized services.

Signature of Authorizing Company Supervisor: _______________________ **Date:**_________________

Authorization Valid Till (Expiration Date):____

PATIENT AUTHORIZATION FOR MEDICAL RECORD RELEASE: I, (Employee's Name), ______________________, do hereby authorize the release and disclosure of medical records, including drug screen results pertaining to my employment from the Urgent Care of the Palm Beaches to my employer, ________________________________'s Human Resource Department. This authorization is valid for two years from the date signed. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting my revocation request in writing to the Medical Records department of the Urgent Care of the Palm Beaches.

Signature of Patient:____ **Date:**________________