ECHN-CorpCare

Occupational Health

Physical Examination/Test & Screen

Consent to Release Results of Examination, Test and/or Screen

I acknowledge that the examination I am about to have is directed toward determining my medical fitness to perform a specific job, or monitoring medical effects of work-related conditions and exposures. It is not meant to replace routine examinations and consultations provided by my personal physician.

Routine examinations by my personal physician are required to address general health issues and medical conditions and to provide important screening tests such as blood pressure measurement and cholesterol levels. I am aware that it is recommended that I see my physician at least once a year or more frequently if health problems arise.

I understand that in the event I do not have my own physician ECHN-CorpCare can assist me, if I so wish, in locating a physician for my basic medical needs.

I hereby authorize ECHN-CorpCare to release to my employer or prospective employer a copy of my examination records, including drugs of abuse testing for the purpose of job placement, regulatory compliance or medical surveillance monitoring.

_____ _____

Examinee Signature Date

******PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM******

2800 Tamarack Avenue Suite 001 South Windsor, CT 06074

Phone 860-647-4796 Fax 860-644-0287

HIPAA

Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by ECHN-CorpCare to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by ECHN-CorpCare may include HIV/AIDS related information, psychiatric and or other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how ECHN-CorpCare will use and disclose my information can be found in ECHN's Notice of Privacy Practices. I understand that this consent is effective for as long as ECHN maintains my protected health information.

By signing below, I understand and acknowledge the following:

- ❖ I have read and understand this consent
- ❖ I have received ECHN's Notice of Privacy Practices currently in effect.

_____ _____

Signature of Individual or Personal Representative Date

_____

Printed Name of Individual or Personal Representative

******PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM******