General Information Form

First Name: _____ Middle Initial____ Last Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell Phone:_____

Date of Birth:_____ Age:_____ Social Security Number (Only Last 4)_____

Marital Status: Married _____ Single_____ Other _____

Company Name: _____

I authorize Workmed Midwest to release my examination results and/or other applicable testing results via electronic portal or mail to the above named company. Information shared in this portal could include the following: FMCSA (DOT) 3 page health history form, DOT medical examiner certificate, physical clearance (Workability), immunization records, OSHA Audiogram and respiratory clearance, and laboratory results.

Signature: _____ Date: _____

Workmed Midwest, PA

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant To HIPAA and Consent for use of Health Information

Name_____ Date of Birth_____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has had the opportunity to read and/or has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manuel is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPPA Compliance Manual, State law and Federal Law.

_____ _____

Patient's Signature Date Signed

**If patient is a minor or under a guardianship order as defined by State Law:

By_____

Signature of Parent/Guardian (Circle One)