GULF COAST OCC MED MEDICAL AUTHORIZATION

Patient to cover cost at time of service $40.00

☐ Main Clinic	☐ Gonzales Safety Council	☐ Siegen Safety Council	☐ Addis Safety Council	☐ Reserve Clinic	☐ Walker Clinic
15389 Airline Hwy Baton Rouge, LA 70817 Ph: 225-753-7233 Hours: M-Th 7:30am-5:00pm Fri 7:30am-4:00pm	1205 W. Edenborne Pkwy Gonzales, LA 70737 Ph: 225-647-8155 Hours: M-F 7:30am-4:00pm	10099 N. Reiger Rd Baton Rouge, LA 70809 Ph: 225-282-3308 Hours: M-F 7:30am-4:30pm	7640 Highway 1 Addis, LA 70710 Ph: 225-282-3278 Hours: M-F 7:00am-3:30pm	3919 W. Airline Hwy Reserve, LA 70084 Ph: 985-479-7860 Hours: 7:30am - 4:30pm	29754 Walker South Walker, LA 70785 Ph: 225-454-6034 M-F 7:30am 3:30pm

Date: _____ SS#:_____

Patient Name: _____

□ Panel #1162 Witnessed Collection Required
*Prescription Determination Needed

RELEASE OF MEDICAL INFORMATION

I, _____ agree to allow Gulf Coast Occupational Medicine, Inc. to release information concerning my medical records to ASCENSION PARISH COURT.

_____ _____

Witness Signature Date

CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

I consent freely and voluntarily to all procedures and medical treatments requested by my employer (either current or potential) or deemed necessary by Gulf Coast Occupational Medicine, Inc. physician(s) for the purpose of pre-employment, annual, random, periodic, reasonable cause or post-accident screening. I agree to disclose to Gulf Coast Occupational Medicine, Inc. the names of all prescription and over the counter medications I am now taking. I acknowledge that there is no guarantee, expressed or implied, as to the results of procedures and medical treatments performed. I hereby release Gulf Coast Occupational Medicine, Inc., its officers, employees and agents from any liability whatsoever arising from this request to furnish this specimen and decisions made concerning my employment based upon the results of the analysis.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Gulf Coast Occupational Medicine, Inc., the physicians, nurses and other staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Gulf Coast Occupational Medicine, Inc.'s operations and responsibilities**.**

_____ _____

Witness **Signature** **Date**

_____ _____

Date **Printed Name**