

**Authorization for Release of Medical Information and Registration Form**

**Please Print all information below**

Social Security # \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Legal First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_  
Cell phone or pager

Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M or F Marital Status: Married Single  
MM DD YY

Company who sent you: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer, if different from the Company that sent you \_\_\_\_\_

Work Location \_\_\_\_\_

Check reason for your visit: \_\_\_\_ Physical \_\_\_\_ Drug Screen \_\_\_\_ Injury \_\_\_\_ Vaccination \_\_\_\_ Other

\_\_\_\_\_ I have been given the Vaccination Information Sheet (VIS), which explains to me the initials risks and benefits of receiving the vaccination I received.

If injury, please describe body part involved: \_\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ - Required  
MM DD YY

Have you been treated for this injury: Yes or No Date of that visit: \_\_\_\_\_

If yes, which medical facility \_\_\_\_\_

Have you ever been seen at any BarnesCare location? Yes or No

**CONSENT FOR TREATMENT**

\_\_\_\_\_ I hereby certify that the foregoing information is true and complete to the best of my knowledge. I request medical treatment described above in conjunction with my above initials referenced employment (either current or potential).

**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 BJC Corporate Health Services (“BarnesCare”), the physicians, nurses and other BarnesCare 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 BarnesCare’s operations and responsibilities.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION\***

\*Please note that this section does not pertain to self-pay patients.

I authorize BarnesCare to release such medical records and information regarding any aspect of my treatment or diagnosis received during my treatment to the above identified employer, and/or their agents or representatives (collectively “Employer”) for the purpose of my employment or potential employment with the Employer. In addition, I authorize the release of my medical records and any information regarding my diagnosis and medical condition to any other health professionals involved in my care, for the purpose of continuing to treat me.

**ATTENTION: Please be advised that once BarnesCare releases this information to the Employer the released information is under the control of the Employer and is no longer protected under the health information privacy regulations. Further, the release information may be subject to re-disclosure by the Employer. I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug and/or alcohol treatment or use.**

I understand that:

- I am here at the request of the identified Employer;
- BarnesCare is treating me and creating health information that will be disclosed to the Employer;
- I must sign this Authorization for Release of Information form as a condition of receiving treatment from BarnesCare; and
- If I do not sign this form, BarnesCare may not treat me as requested by the Employer and will not send this information to the identified Employer.

If I decide to obtain treatment from BarnesCare without signing this form, and BarnesCare decides to provide such treatment, I will pay for all of services BarnesCare provides.

I understand and agree that this Authorization is valid unless I cancel it in writing (as described below) for as long as BJC Corporate Health Services (BarnesCare) stays in business. I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. I understand that if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this authorization. I understand that I need to mail, fax or bring the letter to BarnesCare Attn: Medical Records Supervisor 5000 Manchester, St. Louis, MO 63110, 314-747-5808.

I agree that I have received a signed copy of this Authorization if I chose to receive it.

**If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative.**

\_\_\_\_\_  
Signature of Patient/Legal Guardian/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by BarnesCare Representative

\_\_\_\_\_  
Date

