Concentra®

Employer Services-Authorization For Disclosure of Protected Health Information (PHI) HIPAA Release

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: _____ **Birthdate:** _____

Address: _____

Purpose of Disclosure

☐ **Occupational Injury** ☐ **Occupational Non-injury** ☐ **Other**

Confirmation of Who May Receive Copies of Your Records

Employer or Entity Name: _____

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Fax Number: _____ **Confirmation Telephone Number:** _____

In Connection With This Authorization:

- I am aware that copies of records for services rendered on _____ (date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, medical history, transcription notes, tests, and evaluations performed that my treating clinician(s), employer, prospective employer or third party entity has ordered or requires.
- I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes, psychiatric information, sexually transmitted diseases, alcohol and drug abuse and/or HIV/ AIDS status, which is obtained as part of the evaluation and/or treatment for this work related injury/illness, or employment-related examination.
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.
- I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.
- I may revoke this authorization at any time, but I must do so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject to Workers' Compensation, under some state laws I am not allowed to revoke this authorization.
- I understand that this authorization expires one year from the date of execution, unless revoked in writing, or a shorter expiration date is required by applicable state law.

I have a right to receive a copy of this authorization.

_____ **OR** _____

Signature of Patient's Representative/Date: _____ **Patient's Signature/Date:** _____

_____ _____

Printed Name of Patient's Representative **Explanation of your legal right to sign for Patient**

For HIPAA questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571.

Privacy-Occupational Authorization-ENG 032421

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