# PATIENT REGISTRATION FORM

## EMPLOYER INFORMATION:

**Patient's Employer:** ______________________________________________

**Employer Address:** ______________________________________________

**City:**______________________ **State:**_____ **Zip:** _________ **Employer Phone:** _______________

## PATIENT INFORMATION:

**Social Security #** __________ **Date of Birth:** _________ **Age:**_____ **Sex:** _____ **Martial Status:** ______

**First Name:** ____________________**M.I.** ____ **Last Name:** ____________________________

**Patient's Address:** ______________________________________________

**City:** ______________________ **State:** ____ **Zip:** _________

**Patient's Home Phone:** ____________________ **Cell Phone** ______________________

**Emergency Contact Name:** ____________________________________________

**Relationship To You:** _________________________ **Phone : (**_______**)**_______**-**______________

## CONSENT FOR TREATMENT:

I AUTHORIZE Workforce Health to disclose the information as listed on this authorization of the above named patient to: (COMPANY NAME) ____________________________________________

The purpose of the disclosure is Reimbursement, Medical Care, and Employer Requirements.

The information to be disclosed is: All medical records including, but not limited to: Physician's notes, X-ray reports, Drug/Alcohol testing results, and specialty reports.

This authorization to disclose the listed information expires in 60 days unless a shorter time period is specified on this authorization.

I understand that I may revoke this authorization at any time before the information has been used or disclosed. I must revoke this authorization in writing and submit the written revocation to the office manager (Refer to the La Porte Regional Health System's Notice of Privacy Practices for further information)

Information used or disclosed according to this signed authorization may be re-disclosed by the agency or person receiving this information and may no longer be protected by the HIPPA privacy regulations.

I understand that I am not required to sign this authorization in order to receive medical treatment from Workforce Health, but if I choose not to sign the authorization, I understand that I will be responsible for payment for services rendered.

I consent that I have read, understand, and authorize the consent for medical services, the release of any required medical information.

**Signature:** ____________________________________ **Date:** ____________________

**Witnessed:**___________________________________ **Date:** _____________________