

**OCALA
CHIROPRACTIC
&
INJURY**

DOT Medical Exam Release

Applicant: Driver Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Gender : Male Female

Email: _____ Date of Birth: _____

Driver's License Number: _____ State Issued: _____

Financial Responsibility: Company / Employer Applicant / Driver

Employer Information:

Company Name: _____ Phone number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Contact Person: _____ Phone Number/ Ext: _____

Have you had a DOT Medical Exam previously? Yes No, this is my first DOT Exam

Where did you hear about our services? Employer Word of mouth Social Media

Advertisement/Flyer, if yes please tell us where you saw this: _____

Would you like an automatic reminder text or email before your DOT Card Expires?

Yes No / If yes, Preferred Number and/or Email: _____

Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your personal health information without authorization is strictly limited to defined situations that included emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after your consent. *You may request restrictions on your disclosure. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice.*

I understand that under; the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand these Notice of Privacy Policies. A more complete description can be requested. I also understand that I can request, in writing, restricting how my personal information is used and or disclosed.



I authorize the release of all information obtained in this DOT medical exam to my employer as listed above. **Failures will be automatically and immediately reported to your Employer.**



We are now required to report all test results directly to the FMCSA.

The DOT Medical Exam does not establish a Doctor-Patient Relationship.

Patient Name: _____ Signature: _____

Date: _____