1973 XPRESS URGENT CARE

EMPLOYEE AUTHORIZATION FOR SERVICES

To be Submitted by Employee and Signed by Employee & Authorizing Employer

Company Name:	
Authorized By:	
Company Contact Number:	

Patient (Employee) Name:			
Date of Birth:		**Social Security Number:**	

Is this a Worker's Comp Visit? (On the Job Injury) Complete section below for a Workers Comp visit.

Is there a Post-Accident Drug Screen? ☐ Yes ☐ No

Has the Patient been given a Chain of Custody Form? ☐ Yes ☐ No

☐ Collection Only ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel ☐ DOT Federal

☐ Breath Alcohol Test ☐ Drug Screen-Hair Collection

Work Comp Insurance Carrier:	**Date of Injury:**
Adjuster (If known):	**Claim Number (If known):**

Should medications be sent to a specific pharmacy? ☐ Yes ☐ No

Is this an Occupational Health Visit? *Complete this section for a non-Workers Comp related visit.*

☐ Work Physical	☐ PPD	☐ Chest X-Ray (For Positive PPD)
☐ QuantiFERON Gold TB Test	☐ Hep B Vaccine (series of 3)	☐ Hep A Vaccine (Series of 2)
☐ MMR Titer	☐ Varicella Titer	☐ Flu Vaccine

☐ **Pre-Employment Drug Screen:**

☐ Collection Only ☐ 5 Panel ☐ 7 Panel ☐ 10 Panel ☐ DOT Federal

List any requested services not included in the option list above:
____
____

Special Instructions: ____
____

EMPLOYER AUTHORIZATION: I authorize the above services and understand that my company will be responsible for all services not covered by my Worker's Compensation carrier, including Post-Accident drug screens and breath alcohol tests. I understand that if a claim number is not provided to Xpress Urgent Care in order for them to submit to my Worker's Compensation carrier, that I will be responsible for payment for the treatment of this employee.

Signature of Authorizing Company Supervisor: ______________________________ **Date:**________

PATIENT AUTHORIZATION FOR MEDICAL RECORD RELEASE: I, (Employee's Name)________________________________, do hereby authorize the release and disclosure of medical records, information, and drug screen results pertaining to my work related injury from the medical facility that treated my work related injury to my employer, _________ _______________'s Human Resource Department. This authorization is valid for one year from the date signed. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting my revocation request in writing to the Medical Records department.

Signature of Patient: ____ **Date:**______________