

# Medical Authorization for Treatment

## EMPLOYEE INFORMATION

Date \_\_\_\_\_ Company Name \_\_\_\_\_

Name of Employee \_\_\_\_\_ Plant Location \_\_\_\_\_

Employee Birthdate \_\_\_\_\_ Employee SSN \_\_\_\_\_

Employee Job Title \_\_\_\_\_

## Reason for Visit/Services Desired – Please Check all that Apply

- |  |  |
|--|--|
| <input type="checkbox"/> Worker's Comp/Injury ❶                                    | <input type="checkbox"/> Urine Drug Screen (UDS) ❸   |
| <input type="checkbox"/> Physical Exam – DOT ❷                                     | <input type="checkbox"/> UDS Post-Accident           |
| <input type="checkbox"/> Physical Exam – Pre-Employment ❸                          | <input type="checkbox"/> UDS Random                  |
| <input type="checkbox"/> Breath Alcohol ❹  | <input type="checkbox"/> UDS Reasonable Suspicion    |
| <input type="checkbox"/> PT/OT Evaluation and Treatment ❺                          | <input type="checkbox"/> UDS Pre-Employment          |
| <input type="checkbox"/> X-Ray ❽   | <input type="checkbox"/> Hair Follicle Drug Screen ❹ |
| <input type="checkbox"/> Other Services (vaccinations, etc.) please indicate _____ |  |

## Please Indicate the Location for Services (Please note that not all services are available at all locations.)

- |  |  |
|--|--|
| <input type="checkbox"/> Memorial Health Employer Services<br>695 W. 2 <sup>nd</sup> Street, Suite A1<br>Jasper, Indiana<br>812.996.5750<br>Services: ❶❷❸❹❺❻❼❽ | <input type="checkbox"/> Memorial Orthopaedic Associates<br>695 W. 2 <sup>nd</sup> Street, Suite A2<br>Jasper, Indiana<br>812.996.5950<br>Services: ❶❽ |
| <input type="checkbox"/> Memorial Rehabilitation Services<br>695 W. 2 <sup>nd</sup> Street, Suite D<br>Jasper, Indiana<br>812.996.0682<br>Services: ❺          | <input type="checkbox"/> Huntingburg Urgent Care<br>507 E. 19 <sup>th</sup> Street<br>Huntingburg, Indiana<br>812.683.4717<br>Services: ❶❽             |
| <input type="checkbox"/> Memorial Hospital Emergency Department<br>800 W. 9 <sup>th</sup> Street<br>Jasper, Indiana<br>812.996.2345<br>Services: ❶❹❺❽          | <input type="checkbox"/> Memorial Hospital Laboratory<br>800 W. 9 <sup>th</sup> Street<br>Jasper, Indiana<br>812.996.2345<br>Services: ❹❺              |
| <input type="checkbox"/> Memorial Health Washington<br>600 S. State Road 57<br>Washington, Indiana<br>812.257.1052<br>Services: ❶❷❸❹❺❻❼❽                       | <input type="checkbox"/> Other Location Not Listed<br>_____<br>_____<br>_____  |

**INJURY INFORMATION**

Site and Description of Employee Illness/Injury \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_

Claim # \_\_\_\_\_

**COMPANY CONTACT INFORMATION**

Contact Name \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

Contact Fax Number \_\_\_\_\_

Company Address \_\_\_\_\_

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

I authorize the above employee to be treated for the services/injury/illness noted above and I assume responsibility for the charges incurred.

\_\_\_\_\_  
Company Contact/Authorized Personnel Signature

\_\_\_\_\_  
Date

**EMPLOYEE/PATIENT AUTHORIZATION TO RELEASE**

I, the undersigned, hereby consent to the test(s) noted above for all visits/referrals related to the injury noted above. By signing, I hereby authorize Memorial Hospital and Health Care Center and any attending and/or consulting providers to release return to work information regarding my medical treatment for this injury to my employer and the insurance and/or worker's compensation carrier for which I have assigned benefits for my treatment and care, and to my referring and any other health care provider or facility responsible for my care, if they request it. I will not hold my company, my worker's compensation carrier, any health care provider, medical personnel, hospital, medical center, or clinic legally responsible for the release or use of the physical examination report and/or test results. I agree to accept responsibility for all charges incurred should my employer or insurance plan refuse to pay. I understand a urine or hair follicle analysis will include a test to find out if there are substances in my body that a health care provider did not prescribe and/or illegal substances in my urine or hair. I understand that if I refuse to take any or all of the test(s) noted above, or if I refuse to sign this consent form, the test(s) will not be completed. I also understand that my company will be notified of my refusal. This could result in rejection of my application for employment, rejection of temporary labor services, and/or loss of employment.

\_\_\_\_\_  
Employee/Patient Signature

\_\_\_\_\_  
Date

