CONSENT FOR SCREENING EXAMINATION

I agree to undergo a standard clinical examination and tests which will be utilized to investigate health hazards which might be related to my work. This service, being specific and specialized is not meant to replace medical care provided by my primary physician.

I understand that information concerning my examination will be kept confidential and will be released only upon my written consent, unless legally required, or a serious health risk to other workers is identified. The steps the CNYOHCC may take when such a risk is identified are detailed in a written Policy which is available upon request.

Summaries of the results of the individual and group evaluations may be presented to the union, scientific bodies and other agencies, and may be published in a manner which will not identify me without my written consent.

I acknowledge that the nature and purpose of the examination have been fully explained to me, and that I have had an opportunity to ask any examination related questions I have and that all questions have been answered fully.

SIGNATURE WAIVER

I authorize the Central New York Occupational Health Clinical Center to release information concerning my examination (such as my name, date of service and type of service) necessary to bill the appropriate reimbursement source. I permit a copy of this authorization to be used in place of the original and I request that payment for services furnished be made to Family Medicine Medical Service Group.

I also give permission for you to contact my physician, to discuss my medical history, evaluation and results, if it is found necessary. I give permission to send a copy of any CNYOHCC evaluations to my physician's office, or to other physicians to whom I am referred by CNYOHCC for diagnostic testing or treatment.

Physician's Name and Address:_____

_____

Physician's Phone Number (include area code):_____

PATIENT'S SIGNATURE:_____ DATE:_____

WITNESS:_____

Please submit above and send to cnyohcc@upstate.edu

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