North Kansas City Hospital

NORTH KANSAS CITY HOSPITAL OCCUPATIONAL MEDICINE
WORKERS REHAB
2700 CLAY EDWARDS DRIVE SUITE 120
NORTH KANSAS CITY, MO 64116
Phone # (816) 346-7400 FAX # (816) 346-7104

***Patient:**
Please complete *ALL* blank spaces.

PHYSICAL EXAM CONSENT

Name:_____ **Social Security #**_____
First Name Last Name

Address_____
Street City State Zip

Phone# (____) _____ **Date of Birth**_____ **M**___ **F**___ **Age**____
Area Code Phone Number

Allergies:_____

COMPANY INFORMATION

Company Name_____ **Contact Name**_____
First Last

Authorized by_____ **Phone #**_____
First Name Last Name

AUTHORIZATION FOR EXAMINATION AND TREATMENT AND RELEASE OF MEDICAL INFORMATION

This is to certify that I, the undersigned, consent to the performance of whatever procedures may be decided to be necessary or advisable in the opinion of the company and/or attending physician. I hereby authorize NKCH Occupational Medicine to release all or any portion of my records, including x-rays or laboratory results, and to permit my treating physician to be interviewed regarding my diagnosis, care, and treatment rendered by NKCH Occupational Medicine. This authorization includes, but is not limited to, releasing information to my employer, insurance companies, unemployment and worker's compensation carrier.

Patient Signature **Date** **Witness Signature** **Date**

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have been given the opportunity to review NKCH Occupational Medicine's Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer.

Patient Signature **Legal Representative**