



# DEPAUL COMMUNITY HEALTH CENTERS

## Authorization Form

Patient name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer Street Address: \_\_\_\_\_

### **Work Related:**

Injury  Illness Date of Injury \_\_\_\_\_

### **Physical Examination**

Pre-placement  DOT Physical  Respiratory Physical  Hazmat Physical

### **Other Testing**

PFT  Audiogram  Fit Testing  EKG  Titumus  Ishara  PPD  Quantiferon

### **Substance Abuse Testing\*(check all that apply)**

DOT Drug Screen  Breath Alcohol  Collection Only  Hair Collect

NON-DOT drug screen  Rapid drug screen  Other \_\_\_\_\_

### **Type of Abuse Testing**

Pre-placement  Reasonable Cause  Post- Accident  Random  Follow-up

Direct Observation

### **Vaccines**

Hepatitis Vaccine  MMR Vaccine  Other \_\_\_\_\_

\* Please make sure specific services are marked off.

### Special Instructions/ Comments:

By signing this authorization, the said employer acknowledges full responsibility for payment for ALL services related to examinations, screening diagnostic testing and treatment and or medications deemed necessary by the treating physician for the authorized individual named in this form unless it is previously requested to collect payment at time of service from the individual. It is understood that the services will be paid for in full upon receipt of billing for all amounts due. It is also understood that the employer will be responsible for payment of all services related to injury or illness care of the employee if said case is the determined work related or not, or if the claim is denied by the workers compensation insurance carrier.

AUTHORIZED BY: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_