MERCY HEALTH SYSTEM

INFORMATION REQUEST/AUTHORIZATION OF TREATMENT AND/OR TESTING

PATIENT NAME:____ SS# ___________

COMPANY ____

I authorize Mercy Occupational Health Services/Urgent Care to perform all tests and/or procedures relative to my injury/illness or physical evaluation as deemed necessary by the attending physician/physicians assistant, my employer, or insurance carrier. I understand testing may include, but is not limited to, drug and alcohol screening.

I also request Mercy Occupational Health Services/Urgent Care to release and/or obtain information concerning my present injury, illness, or physical evaluation to my employer, employer's insurance carrier, all treating physicians, representing attorneys, the State Worker's Compensation Board, and any others as listed below.

Other: ____

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____ ____________________
Patient Signature Date

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Witness Signature

Occupational Health Services/Urgent Care
Information Release/Consent for Treatment

Patient Sticker