Pacific Medical Clinic

1534 East Warner Avenue, Suite A
Santa Ana, CA 92705

[Contact information for Privacy Official]

1/ Medical Release & Consent Form

PATIENT INFORMATION

_____
DATE

_____ _____ _____
Name (Last, first, middle initial) Date of Birth Social Security # or Patient ID

_____ _____ _____ _____
Street address (Home) City State ZIP Code

_____ _____ _____
Contact Phone Number Name of Employer Employer Phone Number

I, the undersigned, certify that all the information I have or will furnish in connection with this examination is and will be true and correct. I hereby consent to the examination and any required tests by the physicians and qualified personnel of Pacific Medical Clinic. I understand that this care may include tests, examinations, x-rays and the drawing of blood. I understand that all test results, information learned and findings made in the course of this examination will be released to my employer and I hereby authorize the staff of Pacific Medical Clinic to release this information to my employer.

Patient Signature _____ Date _____

2/ HIPAA Privacy Rights Request Form

I acknowledge that I have had the opportunity to receive a notice of privacy practices, which describes how my medical information may be used and disclosed and how I can get access to this information. I understand that I am entitled to a copy of this information at my request.

Signature _____ Date _____

3/ Alcohol and Drug Screening

Type of Testing to be Performed

☐ *Urine Drug Screen*
☐ *Breath Alcohol Testing*

I, _____ , do hereby authorize Pacific Medical Clinic, or its affiliates or subsidiaries, or any doctor, clinic, laboratory or medical facility designed by it, to collect urine and other samples for alcohol and drug screening as required.

I understand that all alcohol and drug screening test results and evaluations will not be considered confidential medical information and may be discussed with and/or reviewed with my current employer or supervisor.

I further understand, in accordance with my employer's *Statement of Policy on Alcohol and Drug Abuse in the Workplace,* that the results of the testing may affect my employment status with my current employer.

Patient Signature _____ Date _____

Please fill out Part 1 and Part 2, only fill out Part 3 if instructed