OCCUPATIONAL HEALTH & WELLNESS
210 CORNELIA STREET, SUITE 303
PLATTSBURGH, NY 12901
PH: 518-562-7305 FAX: 518-562-7568

PATIENT NAME: ____

DOB: ___ / ____ / ______ **SS#:**_____-_____-______ **EMAIL:** _______________________

ADDRESS: ____

CITY:__________________________________ **STATE:** ____________ **ZIP:**______________

HOME PHONE: _________________________ **CELL PHONE:** ________________________

MARITAL STATUS: (circle one) MARRIED SINGLE DIVORCED SEPARATED

RACE: (circle one) CAUCASIAN/WHITE ASIAN BLACK/AFRICAN AMERICAN

NATIVE AMERICAN/NATIVE ALASKA UNDETERMINED DECLINED

NATIVE HAWIIAN/OTHER PACIFIC ISLANDER

ETHNICITY: (circle one) NON HISPANIC HISPANIC/LATINO UNDETERMINED

PRIMARY LANGUAGE: (fill in the blank) ____

PCP: (Your Regular Doctor) ____

LATEX ALLERGY? (circle one) Yes or No **RELIGION:** _____________________________

DO YOU HAVE A LIVING WILL OR HEALTH CARE PROXY? (circle one) Yes or No

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EMPLOYER: ____

ADDRESS: ____

WORK PHONE: ____

EMERGENCY CONTACT: ____

ADDRESS: ____

HOME PHONE: __________________________ **WORK PHONE:** ______________________

RELATIONSHIP TO YOU: ____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO REPORT A CLAIM TO MY EMPLOYER. A COPY OF THIS SIGNATURE IS VALID AS THE ORIGINAL.

SIGNED: ____________________________________ DATE: ________________________

ACKNOWLEDGEMENT OF RECIPET OF PRIVACY NOTICE

I HAVE BEEN PRESENTED WITH A COPY OF THE UNIVERSITY OF VERMONT HEALTH NETWORK-CHAMPLAIN VALLEY PHYSICANS HOSPITAL-NOTICE OF PRIVACY POLICIES, DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND THE CONTENTS OF THE NOTICE AND I REQUEST THE FOLLOWING RESTRICTIONS CONCERNING THE USE OF MY PERSONAL MEDICAL INFORMATION:

____

____

SIGNED: ___________________________________ DATE: __________________________

Occupational Health & Wellness
210 Cornelia St., Suite 303
Plattsburgh, NY 12901
(518) 562-7305

I hereby give my consent for CVPH- physicians at Occupational Health & Wellness to use and disclose protected health information about me to carry out treatment, payment, and health care operations. (The Notice of Privacy Practices provided by The University of Vermont Health Network-Champlain Valley Physicians Hospital describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. CVPH-Occupational Health & Wellness physicians/providers reserve this right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

CVPH
Attn: Medical Records
75 Beekman Street
Plattsburgh, NY 12901

____ With this consent, CVPH - physicians/providers at Occupational Health & Wellness may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

____ With this consent, CVPH - physicians/providers at Occupational Health & Wellness may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements.

____ With this consent, I understand that CVPH – physicians/providers at Occupational Health & Wellness are now utilizing an Electronic Medical Record.

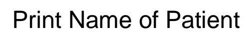
____ With this consent, I authorize CVPH – physicians/providers at Occupational Health & Wellness to have access to my prescription history through the electronic pharmacy network and I acknowledge that this consent will remain in effect from this day forward and as long as I remain a patient at Occupational Health & Wellness unless I choose to revoke said consent.

I have the right to request and restrict how it uses or discloses my personal health information to carry out health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow CVPH – physicians/providers at Occupational Health & Wellness to use and disclose my personal health information to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CVPH – physicians/providers at Occupational Health and Wellness may decline to provide treatment to me.

_______________________________________ ____________________________



Print Name of Patient Patient Date Of Birth

____ ___________________________

Signature of Patient or Patient's Legal Representative Date

____________________________________ ____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Patient (if applicable)