**TANNER CONSENT / ACKNOWLEDGMENT FORM**

I the undersigned, do hereby authorize the Tanner Occupational Health Center, its physicians, employees or agents, together with any hospital or laboratory designated by Tanner Occupational Health Center to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. This includes, but is not limited to, any required medical examinations, x-ray examinations, medical procedures and medical, diagnostic or laboratory tests.

I the undersigned, do hereby authorize the Tanner Occupational Health Center, to request and obtain my medical records from my personal physician or physicians in order to obtain medical history and/or for previous treatment of a work-related injury. This includes, but is not limited to, any required medical examinations, x-ray examinations, medical procedures and medical, diagnostic or laboratory tests.

I hereby voluntarily authorize the Tanner Occupational Health Center, its physicians, employees or agents, together with any hospital or laboratory to obtain a specimen of my urine, blood, and/or breath for the purposes of determining the presence of drugs and/or alcohol.

I understand these tests are taken at the request of my current or prospective employer with respect to my employment and/or employment application. I further understand that the results of my test may be used to determine my fitness for employment, fitness for duty, and fitness for the job for which I am applying.

I further authorize the Tanner Occupational Health Center to disclose to my employer, prospective employer, insurance company and/or any third-party payor all medical information, tests results and findings made during the course of this examination and/or treatment.

By signing this authorization form I acknowledge that I fully read or had this form read and /or explained to me and that I fully understand its contents. I have been given ample opportunity to ask questions, and that any questions have been answered satisfactorily.

I also understand that the refusal to complete drug/alcohol testing may result in the loss of workers compensation benefits and may be in violation of my employers' drug/alcohol testing policy.

**I certify that the Social Security Number provided by me in the space below is mine and is correct.**

**X**_____ **X**_____

**Patient (Student's) signature above** **Date above**

**X**_____

**Patient (Student's) Social Security Number above**

**X**_____ **X**_____

**Parent/Guardian Signature (Patient under 18)** **Relationship to Patient (Write Above)**

*By signing, I certify that I am the parent or legal guardian to the patient listed above.*

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**Witness Signature above**

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**ACKNOWLEDGMENT**

**Patient (Student) Name: X**_____

**Patient Acknowledgment:** I acknowledge that I have received a copy of the Notice of Privacy Practices for Tanner Health System. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

**Signature of Patient (Student): X**_____ **Date: X**_____

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**For Use by THS Personnel Only:** (Complete if patient acknowledgment is not obtained)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgment was not obtained because.

_____.

**Patient/Donor Identified by:**

Picture ID (Driver's license, military ID, etc.)

Two signatures compared to signature on COC

**Signature of THS Representative:** _____ **Date:** _____