SPECTRUM HEALTH
The Medical Group

Record/Consent/Authorization REGISTRATION RECORD/ CONSENT FOR TREATMENT/EMPLOYMENT SCREENING/ AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS - OCCUPATIONAL HEALTH

CONFIDENTIAL

RECORD OF REGISTRATION:

Name:
Last _____ First _____ Middle initial ___ Maiden _____
Date of birth _____ Age _____ Sex: ☐Male ☐Female Phone _____
Social Security number _____ Driver's License number _____
Address _____
Zip _____ State _____ County _____ City _____
Email address _____

Marriage status: _____ Spouse's name _____

Main language: _____

Race: _____

Ethnicity: _____

Disability: ☐Hearing ☐Vision ☐Speech ☐Physically ☐Multiple ☐None
☐Other: _____

COMPLETE THE FOLLOWING ONLY IF A WORK-RELATED INJURY VISIT:

Name of Company you work for _____ Phone _____
Company address _____ Job title _____
Do you work for a temporary agency? ☐Yes ☐No If yes, name of agency _____
Agency address _____ Phone _____
How long have you worked for this company? _____
Date of injury _____ Hour of injury _____ Date last worked _____
What part of your body did you injure? _____ ☐Right ☐Left
How did the injury happen?

_____

Have you already been seen for this condition? ☐ Yes ☐ No
If yes, where? _____

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION:

- I agree to be treated by Spectrum Health, Occupational Services. Treatment may include physical examinations, tests (such as x-rays, blood tests, etc.) and medical treatment. This will be done by the staff of Spectrum Health, Occupational Services. There was no promise made to me about the results of examinations/tests/medical treatments.
- I agree to pay for all treatment given by Spectrum Health, Occupational Health if my company or my company's compensation insurance carrier denies my claim.
- I agree to substance abuse screening

OVER ➔

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

X02770 (09/21)
(Spanish X09333)

X02770

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

- Spectrum Health, Occupational Health will still treat me whether or not I sign this authorization.
- I authorize Spectrum Health to take my picture and save it to my electronic medical record. I understand that Spectrum Health will use this picture for identification purposes with the goal of improving my patient experience as I move throughout the Spectrum Health system.
- I authorize Spectrum Health, Occupational Health to release the substance abuse screening results to my employer.
- Spectrum Health, Occupational Health will give me a copy of this signed authorization if I ask.
- I authorize Spectrum Health, Occupational Health to release my medical records:
  - That only have to do with this visit.
  - That only will be used for employment screening or work-related injury.
  - That could include all lab reports and diagnostic test results.
  - That could include additional records for this treatment as they are recorded in our Electronic Medical Record (EMR). Examples of these additional records may include are, but are not limited to:
    - Records of treatment for this medical condition
    - Reports/Information about substance abuse screening results
    - Acquired immunodeficiency syndrome
    - Acquired immunodeficiency syndrome related complex
    - X-rays
    - Mental illness
    - Venereal disease
    - Tuberculosis
    - HIV infection
- I authorize Spectrum Health, Occupational Health to release my medical records to those noted and for the reasons below:
  - To my potential employer _____ (Name of potential employer), because they are requesting I receive this employment screening service.
  - To the licensed health care professionals or institutions, for the specific reason of caring for me.
  - To me and/or Dr. _____
  - To:
    - Any government agency
    - Employer
    - Doctor
    - Any billing services
    - Any insurance company
    - Any agency that audits either Spectrum Health or a third party payer

    to handle any claims for benefits.

  NOTE: Once Spectrum Health, Occupational Health releases this information, the person/place who receives it must follow Health Insurance Portability and Accountability Act (HIPAA) rules for releasing information.
- This release will be valid until I stop this release. I can stop this release at any time. To stop the release of my medical records, I must let Spectrum Health, Occupational Health know in writing. This would stop the release of future medical records. Information already released can not be recalled.

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X02770 (09/21)
Spanish X09333)

NOTICE OF NONDISCRIMINATION:

Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Spectrum Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. See pages 4 and 5 for the complete notice of nondiscrimination as well as availability of language assistance.

- Spectrum Health will not tolerate discrimination against my doctor, other healthcare professionals or staff because of race, color, gender, national origin, age, disability, sex or any other basis prohibited by federal, state or local law.

- I understand that I may be tested without my consent for HIV, HIV antibody, Hepatitis B and Hepatitis C. This test is allowed by the law of Michigan. This would only happen if a health professional or other health facility employee (that cares for me or handles my body fluid) either gets a needle stick or is in contact with my mucous membrane or open wound. This law protects me, employees of Spectrum Health (doctors/nurses/others), and other healthcare professionals.
- All information I have given to Spectrum Health, Occupational Health is true.
- I have received the Spectrum Health "Patient Privacy" booklet (250899).

PATIENT SIGNATURE(S)

I have read this form and I understand it. All my questions have been answered.

TIME _____ ☐ AM ☐ PM **DATE** _____ Patient signature _____

- Patient is under 18 years of age or otherwise unable to consent because

TIME _____ ☐ AM ☐ PM **DATE** _____

Parent/Legal Guardian/Patient Advocate/Next of Kin signature _____

Printed name _____

STAFF SIGNATURE(S)

TIME _____ ☐ AM ☐ PM **DATE** _____ Witness _____

SECOND WITNESS NEEDED FOR VERBAL CONSENT

TIME _____ ☐ AM ☐ PM **DATE** _____ Witness _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

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Patient printed name _____

Medical record number _____ Account number _____ Date _____

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SPECTRUM HEALTH:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Spectrum Health Language Services at 616.267.9701, 1.844.359.1607 (TTY:711).

If you believe that Spectrum Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex:

- You can file a grievance with:
  Director, Patient Experience
  100 Michigan Street NE, MC 006
  Grand Rapids, MI 49503
  616-391-2624 or toll free: 1-855-613-2262
  patient.relations@spectrumhealth.org
  You can file a grievance in person, by mail or by email. If you need help filing a grievance, the Director of Patient Experience is available to help you.
- You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW, Room 509F, HHH Building
  Washington, DC 20201
  1-800-368-1019 or 800-537-7697 (TDD)
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CONTACT US:

Español (*Spanish*)
ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-359-1607 (TTY: 711).

العربية (*Arabic*)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-359-1607 (رقم هاتف الصم والبكم: 711).

中文 (*Chinese*): 國語/普通話 (*Mandarin*), 粵語 (*Cantonese*)
請注意：如果您講中文，你可以獲得免費的語言輔助服務。請撥打 1-844-359-1607（TTY 手語翻譯：711）。

Tiếng Việt (*Vietnamese*)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-359-1607 (TTY: 711).

Ako govorite srpsko *(Serbian, Croatian or Bosnian)*
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-359-1607 (TTY: 711). (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

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NOTICE OF NONDISCRIMINATION: *(CONTINUED)*

CONTACT US: *(CONTINUED)*

አማርኛ (*Amharic)*
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-359-1607. (መስማት ለተሳናቸው: (TTY: 711).

नेपाली (*Nepali*)
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस 1-844-359-1607 (**टिटिवाइ**: (TTY: 711).

Thuɔŋjaŋ (*Nilotic – Dinka*)
PIŊ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-844-359-1607 (TTY: 711).

Kiswahili (*Swahili*)
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-844-359-1607 (TTY: 711).

فارسی *(Farsi)*
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.844-359-1607 (TTY: 711). **تماس بگیرید.**

Français (*French*)
ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1.844-359-1607 (TTY: 711).

(Burmese)
အသိပေးခြင်း

သင်ပြောသော ဘာသာစကားကို အခမဲ့ ဘာသာပြန်
ရှိပါသည်။ ဖုန်းခေါ်ရန်

فارسی دری (*Dari*)
توجه اگر به زبان دری صحبت می کنید، خدمات کمک زبانی بصورت رایگان برای شما در دسترس است. تماس ب 1-844-359-1607 (TTY: 711).

Kreyòl Ayisyen (*Haitian Creole*)
ATANSYON: Si ou pale Kreyòl Ayisyen, gen èd nan lang ki disponib gratis pou ou. Rele nimewo 1-844-359-1607 (TTY: 711).

Ikinyarwanda (*Kinyarwanda*)
ICYITONDERWA: Niba uvuga ikinyarwanda, serivisi z'ubufasha ku byerekeye ururimi, urazihabwa, ku buntu.
Hamagara 1-844-359-1607 (ABAFITE UBUMUGA BW'AMATWI BIFASHISHA ICYUMA CYANDIKA -TTY: 711).

Soomaali (*Somali*)
DIGTOONI: Haddii aad hadasho Soomaali, adeegyada caawimada luqadda, oo bilaasha, ayaad heli kartaa. Wac 1.844-359-1607 (TTY: 711).

اللهجة السودانية (***Sudanese***)
انتباه: إذا كنت تتحدّث اللهجة السودانية، خدمات المساعدة بلغتك متاحة مجاناً. اتصل على الأرقام 1-844-359-1607 **(رقم الصم والبكم: 711)**.

தமிழ் (*Tamil*)
கவனம்: நீங்கள் தமிழ் பேசினால், உங்களுக்கு இலவசமான மொழி உதவிச் சேவைகள் கிடைக்கின்றன.இந்த எண்ணை அழைக்கவும்: 1-844-359-1607 (TTY: 711).

ትግርኛ (*Tigrinya)*
ትግርኛ (*Tigrinya)*
ትኸረት: ትግርኛ እንደሕር ትዛረብኮንካ፣ ናይቋንቋ ደገፍ ኣልግሎታት፣ ብናጻ ክቐርበልካ እየን። ደዉል 1.844-359-1607 (TTY: 711)።