

**BUSINESS HEALTH PARTNERS**  
299B CITIES SERVICE HWY - SULPHUR, LA 70663 -(337) 626-1011

**PATIENT AUTHORIZATION FORM**

PLEASE PRINT

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

COMPANY NAME \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Race \_\_\_\_\_ JOB TITLE \_\_\_\_\_

**PATIENT INFORMATION**

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

HAVE YOU BEEN TO THIS CLINIC BEFORE? \_\_\_\_\_ YES \_\_\_\_\_ NO

ARE YOU HERE FOR A WORK RELATED INJURY? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, DATE OF INJURY \_\_\_\_\_

**RECORDS RELEASE, AUTHORIZATION & CONSENT**

I HEREBY GIVE MY PERMISSION TO *BUSINESS HEALTH PARTNERS LLC.* TO PERFORM ALL TESTING BEING REQUESTED BY MY EMPLOYER. TESTING MAY INCLUDE URINE, SALIVA. OR BLOOD COLLECTIONS, BREATH ALCOHOL, AUDIO, RESPIRATORY, XRAYs, ETC., AS REQUIRED BY MY EMPLOYER. I AGREE TO THE RELEASE OF ANY AND ALL INFORMATION SURROUNDING RQUIRED TESTING, TO MY EMPLOYER. FURTHERMORE, I AGREE TO THE PRESENCE OF A COLLECTION SITE PERSON, SHOULD MY EMPLOYER REQUIRE IT, WHEN I VOID MY SPECIMEN. GF

I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY QUESTIONS RELATED TO MY HEALTH HISTORY OR CURRENT CONDITION MAY RESULT IN A DENIAL OF ANY RIGHT I, OR MY DEPENDENT (S) MAY HAVE TO WORKERS' COMPENSATION BENEFITS, INCLUDING MEDICAL TREATMENT AND EXPENSES PURSUANT TO LA R.S.#23:1208.1

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS

\_\_\_\_\_  
SIGNATURE OF PATIENT