

Date: _____

PATIENT INFORMATION

 Patient Name: _____ Patient SSN: _____ Patient DOB: _____
 Patient Address: _____
 Patient Phone #: _____ Sex: Female Male

EMPLOYER INFORMATION

 Patient Employer: _____ Employer Phone #: _____
 Employer Address: _____
 Supervisor or Contact Name: _____

INJURY INFORMATION

 Date of Injury: _____ Body Part Injured: _____
 Brief description of how injury occurred: _____

WORKER'S COMP INFORMATION

 Comp Carrier Name: _____ Claim #: _____
 Address to send claims: _____
 Claims Adjuster or Case Manager: _____ Claims Adjuster or Case Manager Phone Number: _____
 Authorization # (if applicable): _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Inova to release the following information to the authorizing company (employer) or the agent designated in their contract with Inova for the purpose of providing my employer with the employment related test results indicated below:

Information to be released/disclosed:

Audiometry Results	Medical Clearance Form	X-Ray Films/X-Ray Reports
Drug and Alcohol Test Results	Pulmonary Function Test	Respirator Medical Clearance
Health History/Physical Exam	Tuberculosis Screening/Vaccinations	
Lab/EKG	Stress Test	

I understand that I am under no obligation to sign this form. Inova may, however, condition the provision of testing on my signature of this authorization to release results to my employer, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, §164.508(b)(4). Inova may also condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that if the person or agency that receives this information is not a healthcare provider or health plan covered by HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of the form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

NOTIFICATION OF RESPONSIBILITY

In the event my workers' compensation claim is denied by my carrier, I agree to be responsible for the cost of this visit and any further care related to this visit, and additional costs associated with enforcing this agreement, including collection costs and reasonable attorney fees.

 SIGNATURE OF PATIENT OR REPRESENTATIVE

 DATE

 If representative, print name and relationship to patient



1HEAR

Inova Staff: At the first opportunity, provide this Special Needs Form to ALL patients and companions. Use completed form to initiate appropriate action and place form in patient's chart.

Patient or companions: It is important to us to communicate thoroughly with all of our patients and companions. To ensure that we provide effective communication during your stay, please complete the information below.

In what language would you prefer to communicate with your providers?	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other (Specify) _____
Are you hard of hearing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If your response is "No" to both questions, then sign the form below. If your response is "Yes" to one or both of the questions, then sign the form below <u>AND</u> complete the information on the Deaf or Hard of Hearing Communication Request Form .
Are you deaf?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Patient's condition does not allow and/or the companion is not available to complete the Special Needs Form.

Spoken language interpreters are available on site or by phone. If you prefer to communicate in a non English language, trained interpreters will be provided to you.

If your communication needs or those of your companion change during your stay/visit, or you need further assistance, please let your caregiver know and we will make accommodations to assist you.

Signature of Patient/Patient Representative/Companion

Date

Print: _____

Relationship to Patient: Self Parent Family Member Friend Other _____

Signature of Employee Witness

Date

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

**INOVA HEALTH SYSTEM
SPECIAL NEEDS FORM**

