

2401 Hickwood Road  
Suite 106  
High Point, NC 27265  
(336) 885-9675



1720 Westchester Drive  
High Point, NC 27262  
(336) 883-4296

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SS #: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

COMPANY: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: (M) \_\_\_\_\_ (F) \_\_\_\_\_

#### **AUTHORIZATION FOR TREATMENT**

I hereby authorize MedCentral, my treating physician, his/her associates, partners or designees, to perform any/or all tests and procedures, relative to my physical evaluation and deemed necessary or advisable by my attending physician, my employer or insurance carrier. This will include, but not limited to, urine drug screens, breath or blood alcohol testing, all laboratory testing, x-rays, physical therapy, psychological evaluations, strength testing, pulmonary function testing and medical evaluations as required.

I also consent to the drawing and testing of my blood for exposure to Hepatitis and Human Immunodeficiency Virus (HIV) in the event that any individual involved with me care at MedCentral and/or its affiliates will remain confidential. However, I consent to the release of the test results to the exposed individual through his/her treating physician.

#### **AUTHORIZATION FOR RELEASE OF SCREENING INFORMATION**

I understand that any pre-placement or annual physical my employer may request is voluntary on my behalf. I authorize MedCentral to share all information obtained during this voluntary evaluation/examination with my employer.

#### **FINANCIAL CONSENT AND GUARANTEE**

I certify that the information given at the time of registration is correct. I understand that in the event that my employer determines my physical evaluation not to be work related, I will be financially responsible for all charges.

Signature of Patient or Legal Representative : \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_