Comprehensive Occupational Medical Services
51 Webster Street
North Tonawanda NY 14120
Phone: (716) 692-6541 Fax: 692-7091

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PHYSICAL, MEDICAL AND / OR PSYCHIATRIC INFORMATION TO IME COMPANY / WORKERS' COMPENSATION PARTIES / EMPLOYER.

I hereby authorize Comprehensive Occupational Medical Services, to perform a history, physical exam and lab testing. I further authorize release and full disclose of this information to the designated medical department concerning my complete physical, medical and/or mental well-being as it relates to my ability to perform the duties of the position to which I am seeking appointment or to perform the duties of the position in which I am currently employed.

I understand that in certain instances this information may be utilized for the purpose of determining whether I am a person with a disability and whether a reasonable accommodation (if requested) can be made which would enable me to perform the essential duties of the position. I also understand that my failure to provide this authorization may prevent my employer from obtaining sufficient information to make an informed decision concerning my employment.

NAME: ____________________

DOB: ____________ SS Number: ____________

ADDRESS: ____________________

CITY: ____________ STATE: ______ ZIP: ________

CELL PHONE: ____________ HOME PHONE: ____________

EMAIL: ____________________

This authorization expires in 90 days or on __________.

I have been offered and/or supplied a copy of the HIPAA regulations.

____________________ ____________
Signature Date

In the event my insurance denies this claim, I agree to be personally financially responsible to pay for medical services rendered by COMS.

____________________ ____________
Signature Date