Authorization for Use of Disclosure of Medical Information, Assignment of Benefits, and Acknowledgement of Notice of Privacy Practices

Patient Name: _____
LAST FIRST M I MAIDEN OR OTH E R NAME
Address: _____ City: _____State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Date of Birth:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Sanford Health Occupational Medicine to disclose my health information including all test results, medical record documentation, demographic or any other information collected during my visits to facilitate my work injury treatment or employment screening to the following individuals or entities:

A. My employer. I understand that health information provided to my employer is no longer protected by healthcare privacy regulations.
B. My primary care physician or any other healthcare provider for follow-up care or medical treatment.
C. Any health insurer, third party payer, or other entity that I have disclosed to Sanford Health Occupational Medicine as being responsible to pay some or all charges associated with my testing or medical treatment.
D. Individuals or entities which support the healthcare operations of Sanford Health Occupational Medicine. Healthcare operations may include quality assessment and improvement, medical student education, business planning and development, legal or auditing services.

I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment or screening services from Sanford Health. I also understand that if I refuse to sign my employer may refuse to pay for the services provided and therefore I will be responsible for the payment.

I may revoke this authorization at any time by sending written notification to the Sanford Health Occupational Medicine. However, a revocation is not valid for any prior action taken in reliance on this authorization.
This authorization expires upon the completion of my employment screening period or the end of my work related injury claim.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship to Patient (if not patient signing)

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I assign and authorize my employer or any third party payer/insurer to make payment directly to Sanford Health Occupational Medicine. I authorize the refund of overpaid insurance benefits back to the insurance company when my coverage is subject to coordination of benefits. I agree that I am financially responsible for all charges related to services provided by Sanford Health Occupational Medicine. If I have questions about my financial responsibility for Sanford's charges, or would like to see a copy of Sanford's
Collection Policy; I may contact Sanford's Patient Financial Services.

Additionally, I agree Sanford Health Occupational Medicine, or its designee, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Sanford may also contact me by sending text messages. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read the information above, and have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the above label or on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship to Patient (if not patient signing)

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Sanford Health's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. The Notice of Privacy Practices may be changed at any time. I may obtain a copy of the Notice from any Sanford Health location or at www.sanfordhealth.org.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship to Patient (if not patient signing)

Sanford OCCMED
3838 12th Ave N
Fargo, ND 58102
Phone: (701) 234-4700 Fax: (701) 234-4757

NAME: _____ SSN: _____

DOB: _____ HOME TELEPHONE # : _____

ADDRESS: _____

EMPLOYER: _____

RESPIRATOR MEDICAL QUESTIONNAIRE

To the employee:

Can you read (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1. (MANDATORY) The following information must be provided by every employee who has been selected to use any type of respirator (PLEASE PRINT).

Name:_____ Today's Date: _____

Age:_____ Sex: _____ M _____ F Height: _____ft. _____inches Weight _____ lbs.

Your Job Title:_____

Check the type of respirator you will use (you can check more than one category):

a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ☐ Other type (for example, half- or full-facepiece type, powered-air purifying supplied-air, self-contained breathing apparatus).

Have you ever worn a respirator? ☐ YES ☐ NO

If "yes" what type_____

PART A. SECTION 2 (MANDATORY) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (Please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO

2. Have you ever had any of the following conditions?
   - a. Seizures (fits): ☐ YES ☐ NO
   - b. Diabetes (sugar disease): ☐ YES ☐ NO
   - c. Allergic reactions that interferes with your breathing: ☐ YES ☐ NO
   - d. Claustrophobia (fear of closed-in places): ☐ YES ☐ NO
   - e. Trouble smelling odors: ☐ YES ☐ NO

3. Have you ever had any of the following pulmonary or lung problems?
   - a. Asbestosis: ☐ YES ☐ NO
   - b. Asthma: ☐ YES ☐ NO
   - c. Chronic bronchitis: ☐ YES ☐ NO
   - d. Emphysema: ☐ YES ☐ NO
   - e. Pneumonia: ☐ YES ☐ NO
   - f. Tuberculosis: ☐ YES ☐ NO
   - g. Silicosis: ☐ YES ☐ NO
   - h. Pneumothorax (collapsed lung): ☐ YES ☐ NO
   - i. Lung cancer: ☐ YES ☐ NO
   - j. Broken ribs ☐ YES ☐ NO
   - k. Any chest injuries or surgeries ☐ YES ☐ NO
   - l. Any other lung problems that you've been told about: ☐ YES ☐ NO

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - a. Shortness of breath: ☐ YES ☐ NO
   - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? ☐ YES ☐ NO
   - c. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ YES ☐ NO
   - d. Have to stop for breath when walking at your own pace on level ground: ☐ YES ☐ NO
   - e. Shortness of breath when washing or dressing yourself: ☐ YES ☐ NO
   - f. Shortness of breath that interferes with your job: ☐ YES ☐ NO
   - g. Coughing that produces phlegm (thick sputum): ☐ YES ☐ NO
   - h. Coughing that wakes you early in the morning: ☐ YES ☐ NO
   - i. Coughing that occurs mostly when you are lying down: ☐ YES ☐ NO
   - j. Coughing up blood in the last month: ☐ YES ☐ NO
   - k. Wheezing: ☐ YES ☐ NO
   - l. Wheezing that interferes with your job: ☐ YES ☐ NO
   - m. Chest pain when you breath deeply: ☐ YES ☐ NO
   - n. Any other symptoms that you think may be related to lung problems ☐ YES ☐ NO

   If any Yes answers, explain below (date of diagnosis and types of treatments):

   _____

   _____

5. Have you ever had any of the following cardiovascular or heart problems?
   - a. Heart attack: ☐ YES ☐ NO
   - b. Stroke: ☐ YES ☐ NO
   - c. Angina: ☐ YES ☐ NO
   - d. Heart failure: ☐ YES ☐ NO
   - e. Swelling in your legs or feet (not caused by walking): ☐ YES ☐ NO
   - f. Heart arrhythmia (heart beating irregularly): ☐ YES ☐ NO
   - g. High blood pressure: ☐ YES ☐ NO
   - h. Any other heart problem that you've been told about: ☐ YES ☐ NO

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: ☐ YES ☐ NO
   b. Pain or tightness in your chest during physical activity: ☐ YES ☐ NO
   c. Pain or tightness in your chest that interferes with your job: ☐ YES ☐ NO
   d. In the past two years, have you noticed your heart skipping or missing a beat: ☐ YES ☐ NO
   e. Heartburn or indigestion that is not related to eating: ☐ YES ☐ NO
   f. Any other symptoms that you think may be related to heart or circulation problems: ☐ YES ☐ NO

7. Do you currently take medications for any of the following problems?
   a. Breathing or lung problems: ☐ YES ☐ NO
   b. Heart trouble: ☐ YES ☐ NO
   c. Blood pressure: ☐ YES ☐ NO
   d. Seizures (fits): ☐ YES ☐ NO

8. If you've used a respirator, have you ever had any of the following problems?
   a. Eye irritation: ☐ YES ☐ NO
   b. Skin allergies or rashes: ☐ YES ☐ NO
   c. Anxiety: ☐ YES ☐ NO
   d. General weakness or fatigue: ☐ YES ☐ NO
   e. Any other problem that interferes with your use of a respirator: ☐ YES ☐ NO

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ YES ☐ NO

Question 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering the questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)? ☐ YES ☐ NO

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses: ☐ YES ☐ NO
   b. Wear glasses: ☐ YES ☐ NO
   c. Color blind: ☐ YES ☐ NO
   d. Any other eye or vision problem: ☐ YES ☐ NO

12. Have you ever had an injury to your ears, including a broken eardrum? ☐ YES ☐ NO

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing: ☐ YES ☐ NO
   b. Wear a hearing aid: ☐ YES ☐ NO
   c. Any other hearing or ear problems: ☐ YES ☐ NO

14. Have you ever had a back injury? ☐ YES ☐ NO

15. Do you currently have any of the following musculoskeletal problems? ☐ YES ☐ NO
   a. Weakness in any of your arms, hands, legs, or feet: ☐ YES ☐ NO
   b. Back pain: ☐ YES ☐ NO
      If so, when:_____ Current treatment:_____
   c. Difficulty fully moving your arms and legs: ☐ YES ☐ NO
   d. Pain or stiffness when you lean forward or backward at the waist: ☐ YES ☐ NO
   e. Difficulty fully moving your head up or down: ☐ YES ☐ NO
   f. Difficulty fully moving your head side to side: ☐ YES ☐ NO
   g. Difficulty bending at your knees: ☐ YES ☐ NO
   h. Difficulty squatting to the ground: ☐ YES ☐ NO
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ YES ☐ NO
   j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ YES ☐ NO

Signature: _____ Date: _____