AA - Participant Authorization
Occupational Health Services (hearing)

Occupational Health Services:
Your employer has contracted with Premise Health Employer Solutions, LLC, along with its professional affiliates (collectively, "Premise Health") to provide occupational health services to individuals at its Health Center ("Occupational Health Services").

Consent for Treatment: I consent to Premise Health providers and center staff to provide occupational medical evaluation, screening, and treatment, for hearing testing and exams.

Protection of Your Health Information: Premise Health abides by all applicable laws and regulations governing the privacy and security of your health information. To the extent that your occupational health encounter is subject to the requirements of the OSHA Hearing Conservation Amendment to the Noise Standard [29 CFR 1910.95] and to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), Premise Health complies with and maintains the privacy and security of your Protected Health Information, as defined under HIPAA ("PHI") in accordance with its Notice of Privacy Practices ("Notice"). You will find this Notice at the Health Center and on the Premise Health website [https://www.premisehealth.com/privacy-policy-center/privacy-notice/]. You may also request a copy of this Notice from Premise Health at any time by contacting the Health Center.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Occupational Health Services Authorization: You understand that you may revoke this authorization at any time by submitting notice of your revocation in writing to the Health Center. You understand that your revocation of this authorization does not affect any actions taken prior to receipt of your revocation. You further understand that your revocation of this authorization may impact your ability to participate in the Occupational Health Services. You understand that this information may be disclosed through electronic means. You also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature and Copy: I have read and understand this form in its entirety and voluntarily authorize the uses and disclosures of the information described above. I understand that should my hearing test results indicate a shift/STS, I will need to sign a specific release of information form that will authorize Premise Health to review the minimum necessary relevant medical information needed to satisfy the requirements for fully investigating the shift. I acknowledge that the person executing this form is the person participating in or receiving services. I further acknowledge I am at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.

Participant

First Name:_____ Last Name:_____ Date of Birth: _____

Participant or Legal Representative Signature:_____ Date:_____