Patient Treatment Authorization & Acknowledgement Form

Today's Date					
PATIENT INFORMATION					
LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	
DATE OF BIRTH:	SEX:	AGE:	PHONE (H):	PHONE (O):	
STREET ADDRESS:					
CITY:	State Alabama		ZIP CODE:		
EMPLOYER:			EMPLOYER'S PHONE:		
EMPLOYER'S ADDRESS:					
CITY:	State Alabama		ZIP CODE:		

AUTHORIZATION AND ACKNOWLEDGEMENT

I consent to the recommendation of medical personnel from Trinity Medical Management, L.L.C ("Trinity") I also consent to Trinity's releasing medical information requested by my employer or by my medical providers. I acknowledge that I am aware that I am entitled to a copy of Trinity's Notice of Privacy Practices. A copy is available for my review in the infirmary / sick bay. Upon my request, a copy will be furnished to me. I agree to comply with my employer's breath/blood alcohol testing and/or drug screening program. I also understand that if I test positive for alcohol and/or drug use, I will be subject to disciplinary actions under my employer's substance abuse program, which may include the termination of my employment.

_____ _____

Employee Signature Date

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