CENTRAL MONTANA MEDICAL CENTER
Lewistown, MT

CONSENT TO TREATMENT AND RELEASE OF RESPONSIBILITY
OCCUPATIONAL HEALTH

Information Privacy: I acknowledge receipt of Central Montana Medical Center's Notice of Privacy Practices. CMMC's Occupational Health staff will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations.

Consent to Treatment: I consent to have treatment or physical examination / testing performed by the physician, nurse practitioner and / or professional staff at Central Montana Medical Center Occupational Health Services department. I permit the physician, nurse practitioner, this facility, and its employees and all other persons caring for me to treat me in ways they judge are beneficial to me, or have been requested by my employer or prospective employer. I understand that this care may include test, examinations, x-rays, and the drawing of my blood.

If You Intend To File A Claim for a Work-Related Injury

If you are claiming a work-related injury, you MUST PROMPTLY notify your employer of this injury and provide the necessary information for your employer to file a workers' compensation claim for the accident. A claim must be filed and approved in order for medical benefits to be paid. If your injury is ruled NOT work-related, or you fail to follow the required procedures for making a claim, you will be responsible for the payment of your bill for all medical services provided.

RELEASE OF RESPONSIBILITY: In consideration of the services of the Central Montana Medical Center Occupational Health Department, their agents, owners, officers, volunteers, participants, employees and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as Occupational Health), I hereby agree to release and discharge the Occupational Health staff on behalf of myself, my children, my parents, my heirs, designee, personal representative and estate for all claims, demands, grievances and causes of action of every kind whatsoever and including but not limited to: liability for all damages of any kind, nature or description now existing or which may hereafter arise from or out of errors, injuries and damages resulting from tests, reports, activities or any action taken in pursuit thereof, whether known or unknown, permanent or otherwise, received as the result of any action taken by Central Montana Medical Center Occupational Health Staff on or about the date of or as a result of this consent.

I have read this payment policy and understand it. I have witnessed the preparation of any sample forwarded to a testing laboratory. My questions have been answered to my satisfaction.

____ **Date:** ____________ **Time:** __________
Signature of Patient or Patient's Agent or Representative

____ ____
Relationship to Patient **Witness Signature**