Walk-In Clinic
ACADIAN HEALTH SERVICES, INC.

6011 Ambassador Caffery Parkway Youngsville, LA 70592
P.O. Box 51775 Lafayette, LA 70505
Phone 337-234-9925 • Fax 337-237-5211

Occupational Medicine: Consent and Release Form - Patient to Complete Shaded Area

Name:

Address:

City: State: Zip:

Phone: Date of Birth:

Cell: Social Security #:

Check One: ☐ Male ☐ Female Email Address:

Company:

Emergency Contact: Relation: Phone:

I voluntarily consent to a job placement and/or periodic medical health screen, including but not limited to a physical examination, the collection of samples, photographs and testing. I hereby authorize you to release to an authorized representative of the company listed any and all medical information, records, photographs and reports, including X-ray reports and findings and reports of specialists or other physicians consulted regarding this examination, pertaining to any treatment or examination which you or your associates have rendered.

This also authorizes you to discuss my medical status in its entirety with an authorized representative of the company listed. I voluntarily agree to release and hold harmless the physician, clinic, clerical and other employees involved in the placement procedure from an action, claim or liability which may arise from this job placement screen or the disclosure of any of its results. I hold harmless the clinic from any and all actions by other related parties. I also agree to indemnify (make compensation for loss damages) the health staff for any expenses incurred should action be taken against the clinic.

I understand that this medical job placement health screen is not a full scope physical examination, but a limited screen for the purpose of job placement. I also understand that if I have a present complaint, I will bring this up with my regular treating physician for further evaluation and will notify the examining physician if a condition exists which could prevent me from completing this examination.

I hereby declare that the answers given by me in the job placement health history are full, complete and true to the best of my knowledge and that I have concealed nothing from my examiner. By signing this statement, I acknowledge that these answers are as truthful as if I were in a court of law and had been sworn to tell the truth. I understand that if it is later found that statements made herein are untrue and false, the opinion of the physicians as to my fitness for job placement may no longer remain the same. I assume all responsibility for any actions, claims, or liability which may result from false statement(s).

DECLARATION: PURSUANT TO LSA-RS23:208.1, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY QUESTIONS, MAY RESULT IN THE DENIAL OF ANY RIGHTS I OR MY DEPENDENTS MAY HAVE TO WORKER'S COMPENSATION BENEFITS, INCLUDING MEDICAL TREATMENT AND EXPENSES. FAILURE TO ANSWER TRUTHFULLY MAY INVALIDATE THE OPINION OF THE EXAMINER. I HAVE READ OR WAS READ TO AND UNDERSTAND THE ABOVE AND SIGNING WITH FULL CONSENT SWEAR/AFFIRM THE ANSWERS ARE TRUE AS IF IN A COURT OF LAW. I AUTHORIZE ANY PHYSICIAN/MEDICAL FACILITY/COMPANY TO RELEASE ANY AND ALL MEDICAL RECORDS AT AHS WALK-IN CLINIC, INC. TO FACILITATE COMPLETING THIS JOB PLACEMENT HEALTH SCREEN.

Date: Print Name: Signature: