Land Sea and Air Medical Review Specialists
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NOTICE OF PRIVACY

Dear Patient:

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. Beginning April 14, 2003, physicians must comply with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, the physician will need to consider the privacy rule. All health information, including paper records, oral communication, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions, these rights are not absolute. We also take precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask our staff about exercising your rights, or how your health information is protected in our office.

Please let us know if you have any questions about our Notice of Privacy Practices. You may speak to our supervisory staff to discuss any questions that you may have. Please sign below to acknowledge that you were informed of your rights.

Thank you.

Patient signature: _____ Date:_____

******* Indicate who is authorized to receive your medical information other than yourself.**

1. _____ 2._____ 3. _____

LAND, SEA & AIR MEDICAL REVIEW SPECIALISTS
PATIENT INFORMATION SHEET

NAME_____

DATE OF BIRTH_____/_____/_____SOCIAL SECURITY#_____-___-_____

ADDRESS_____
CITY, STATE_____ZIP CODE_____
HOME PHONE:(_____)_____

NAME OF COMPANY_____
COMPANY ADDRESS_____
CITY, STATE_____ZIP CODE_____
COMPANY PHONE:(____)_____
How did you hear about LSA**?**_____

CONSENT FOR RELEASE OF MEDICAL RECORDS

I,_____understand that I am requested to take any testing agreed upon between myself and my current or prospective employer_____ as required by the Department of Transportation and/or the company's policy of which I am affected. I am aware that a copy of my test results will be forwarded to my current or prospective employer; such copy shall include all pertinent medical information, including my medical history, which is part of the DOT physical form or company requested examination.

_____ _____
Signature Date

TEST REQUESTED

PHYSICAL:_____DOT 19a_____COAST GUARD_____OSHA_____GENERAL_____

DRUG SCREEN:
Pre-employment_____ Periodic_____Random____ Post-accident_____Reasonable Cause____
Alcohol Test_____Blood Work____Injection Only_____Type_____ PPD _____
Hepatitis Injection: One_____ Two_____ Three____

COMPANY PAY: _____ **EMPLOYEE PAY:_____**

URINANALYSIS

GLUCOSE_____BILIRUBIN_____KETONE_____
SPGR_____BLOOD_____PH_____
PROTEIN_____URIOBILI_____NITRITE_____
LEUK_____