EMERGENCY RESPONDERS HEALTH CENTER
9976 WEST EMERALD STREET | BOISE, ID | P: 208.229.3742 (ERHC) | F: 208.229.8450

PATIENT INFORMATION			
Name (First, Last):		Date of Birth:	
Department:			
Reason for Today's Visit:			
☐ Worker's Compensation Injury	☐ Other Injury	☐ Other Medical Condition	☐ Annual Wellness Exam

CONSENT TO TREAT:

I consent to undergoing medical services provided by Emergency Responders Health Center (ERHC) providers and employees, inclusive of reasonable and necessary medical exams, diagnostic testing, and treatment.

I understand that I have the right to be informed about my medical condition, including the risks and benefits of any diagnostic or medical procedures recommended by my provider. I understand that I may refuse any recommended diagnostic procedure or treatment at any time; however, I acknowledge that my refusal of any recommended procedure or treatment may impact my provider's ability to effectively assess or manage my condition.

I agree that this Consent will continue in perpetuity, following my initial exam, diagnosis, and treatment plan. I understand that I may request a copy of, or revoke, this Consent at any time. However, this revocation will not apply retro-actively to services already provided by ERHC, pursuant to this agreement. To revoke this Consent, I must submit a written request to:

Attention: Lead Patient Liaison
Emergency Responders Health Center
9976 West Emerald Street
Boise, ID 83704

I understand I have the right to discontinue services at any time.

Patient Signature:		Date:	

FRONT OFFICE USE - COMPLETE THE FOLLOWING SECTION FOR:
☑ Worker's Compensation Injuries

AUTHORIZATION TO RELEASE INFORMATION TO EMPLOYER:

I authorize Emergency Responders Health Center to disclose to authorized representatives of the Department named above, healthcare records and other pertinent medical information as is necessary to determine my fitness for duty, including recommendations regarding medical clearance for full active-duty status, or modified duty contingent upon stated accommodations and restrictions.

I understand that ERHC will not disclose my personal medical information beyond that which is necessary to determine my qualifications for duty with the Department. I understand that I have a right to request a copy of official correspondence shared with the Department regarding my health status.

ERHC provider medical clearance assessments are made based on essential job tasks defined by respective first responder agencies. I understand that the actual terms of my employment, including specific duty assignments, are made by my Department. ERHC is not liable for employment decisions or duty assignments made by the Department or its representatives or agents, nor is ERHC liable for my performance or safety on or off duty.

I understand that I may request a copy of, or revoke, this Authorization at any time. However, this revocation will not apply retro-actively to information already disclosed by ERHC, pursuant to this agreement, or to information subsequently re-disclosed by my Department. To revoke this Authorization, I must submit a written request to:

Attention: Lead Patient Liaison
Emergency Responders Health Center
9976 West Emerald Street
Boise, ID 83704

I understand unless revoked by me, this Authorization will expire two years from the date it is executed.

Patient Signature:		Date:	