

Minor Med, PA

1119 SW Gage Blvd, Topeka KS 66604

Phone: (785) 272-4000

www.minormedtopeka.com

Worker's Compensation/ Employment Related Testing Form

Patient Name _____ Date of Birth _____

Social Security Number _____

Employer's Name _____

Employer's Address _____

City _____ State _____ Zip _____ Employer Ph # _____

Injury:

Date of Accident: _____ Time of Accident: _____ AM/PM

Has your supervisor been notified? Yes No

Supervisor's Name: _____

Brief description of accident or reason for being seen today: _____

Authorization for release of medical records: I hereby authorize Minor Med, PA to release all medical records necessary for the processing and payment of my worker's compensation claims related to the injury indicated above and/or employment related testing. I also agree to pay for any bills incurred, in the event that they are deemed not to be a worker's compensation injury and/or employment related testing.

Note: Any false statements on this document could lead to a police report if the bill is not paid.

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 5/20/2008.

Signature: _____

Date: _____

Office Use Only

Authorization:

For Office Use Only.

Attach to Medical Record

Time: _____ **AM/PM**