

**EMPLOYER CONTACT DRUG TESTING, ALCOHOL TESTING AND  
 CONFIDENTIAL MEDICAL INFORMATION RELEASE FORM**  
 (PLEASE COMPLETE ENTIRE FORM & FAX BACK TO 610-954-3242 OR 800-578-9138)

ORIGINATOR'S FAX TRANSMITTAL INFO	
DATE: _____	TIME: _____
TO: _____	
RECEIVER'S FAX #: _____	
FROM: _____ Dorrit Emerich	

RECIPIENT'S RETURN FAX TRANSMITTAL INFO	
DATE: _____	TIME: _____
TO: _____ Andrea Alonzo	
RECEIVER'S FAX #: _____ 610-954-3242	
FROM: _____	

In order to ensure confidentiality in the reporting of drug and alcohol testing or release of confidential medical information to the Employer or below listed third party representatives in accordance with Federal Regulations 49 CFR Parts 40, 391, & 382, we need to establish positive identification of authorized personnel when relaying drug screening results, breath alcohol test results, physical examination results or other medical information.

So that we may establish and/or update our records, we are requesting that you complete the following sections by providing the names, social security numbers and dates of birth of all personnel authorized to receive these results. ***The last four digits of the social security number and/or the birth date excluding the year are acceptable.*** We will require this information before discussing any results.

**CORPORATE OFFICE:**

<b>EMPLOYER:</b> _____	<b>PHONE:</b> _____
<b>ADDRESS:</b> _____	<b>FAX:</b> _____
<b>CITY, STATE, ZIP:</b> _____	<b>E-MAIL:</b> _____

**LOCAL OFFICE:**

<b>EMPLOYER:</b> _____	<b>PHONE:</b> _____
<b>ADDRESS:</b> _____	<b>FAX:</b> _____
<b>CITY, STATE, ZIP:</b> _____	<b>E-MAIL:</b> _____

EMPLOYER AUTHORIZED CONTACTS (IN ORDER) : (for physical and/or substance abuse testing)
1. _____ Birthdate _____ SS# _____
2. _____ Birthdate _____ SS# _____
3. _____ Birthdate _____ SS# _____

EMERGENCY / AFTER HOURS CONTACT INFO
Provide an authorized contact to whom positive drug and/or alcohol test results can be called to after normal working hours. Please list the order & phone #.
1. _____ Phone: _____
2. _____ Phone: _____

**How do you wish to receive physical and/or drug screen results?**

All positive results will be called.

Immediate drug screen results (positive & negative) are called unless specified otherwise.

\_\_\_ Mail only

\_\_\_ E-mail lab-tested (non-immediate) negative results, then mail hard copies

\_\_\_ Other:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MAIL RESULTS TO:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SEND BILLING TO:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**WORK INJURY INFORMATION**

Report To Employer forms will be faxed to company contact.

**EMPLOYER CONTACTS FOR WORK INJURIES:**

**PHONE AND FAX #'S IF DIFFERENT FROM FIRST PAGE:**

1. \_\_\_\_\_

P \_\_\_\_\_ F \_\_\_\_\_

2. \_\_\_\_\_

P \_\_\_\_\_ F \_\_\_\_\_

\_\_\_ Is your company self-insured?

\_\_\_ Does your company have a TPA?

Workers Compensation Insurance Carrier:

TPA:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments:

\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I am an authorized representative of the above listed employer. I hereby authorize the release of any information to the above listed contacts and indemnify **St. Luke's Occumed Resources - Bethlehem and Quakertown** against any claims or liabilities which may incur from the release of these confidential records and agree to reimburse any costs, expenses, including attorney fees resulting from their release of this information.

**Signature of**

**Authorized Rep:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_