MARS Program

MOBILE MEDICAL CORPORATION

PARTICIPANT CONSENT FORM

Last Name: _____ **First:** _____ **Date of Birth:** _____
(Please Print)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Mobile Phone:** (_____) _____

Social Security Number: _____ ☐ **Non-Union:** _____

CRAFT/TRADE:

_____ Asbestos	_____ Iron Worker	_____ Plumber
_____ Boilermaker	_____ Laborer	_____ Roofer
_____ Bricklayer	_____ Millwright	_____ Sheet Metal Worker
_____ Carpenter	_____ Operating Engineer	_____ Sprinkler Fitter
_____ Cement Mason	_____ Painter	_____ Steamfitter
_____ Dry Wall Finisher	_____ Pipe Fitter	_____ Other _____
_____ Electrician	_____ Plasterer	

MANAGEMENT:

Project Manager _____
Supervisor _____
Office / Admin _____

Local Union #_____ **STATUS:** **Please Circle** **Journeymen** **Apprentice**

CONTRACTOR You Are Working For: _____

** Please Check and Sign

☐ **I have received a copy of the Silica Hazard Awareness pamphlet.**

_____
Signature

Release of Test Information

The test that you are taking is to establish Employment Eligibility. - I give authorization for the release of this test information **and understand that the** test information will be available **only** to the Signatory Parties of this Program, for establishing employment eligibility. **I also understand that all Test information** will be secured **and treated as confidential with released only** to Designated Representatives of this Program **and that all** Designated Representatives are **federally mandated HIPAA** compliant**, who too must** protect **confidentiality of the test information.**

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Mobile Medical Privacy Officer. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Mobile Medical Privacy Officer. I'm aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

I have had an opportunity to review and understand the content of this consent and release form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Participant : _____ Date: _____

Please fax completed form to (440) 356-9238