



## **Employee Health & Safety**

Welcome to Physicians Immediate/Urgent Care,

In order to promote and maintain a safe and healthy environment for our employees, patients and visitors, the following vaccinations or proof of immunity, are required prior to beginning work:

- Hepatitis B Vaccines x 3, Titer showing immunity, or Declination statement
- QuantiFERON titer
- MMR Vaccines x 2 or Titer showing immunity to: Rubeola, Mumps, and Rubella
- Varicella Vaccines x 2 or Titer showing immunity
- Latex Allergy Questionnaire (provided below)
- Influenza Vaccine if hired September – March.
- Tdap Booster, recommended every 10 years
- COVID-19 Vaccine, strongly recommended  
(2-doses for Moderna & Pfizer, 1-dose for Johnson & Johnson)

To save time and a needle stick, please complete the HIPAA compliant release of immunization information form. Save a copy to your computer and attach the completed forms in an email to [eh@visitphysicians.com](mailto:eh@visitphysicians.com).

If records cannot be obtained, PIC will provide you with either titers or vaccinations depending on employee needs.

If you have any questions, please contact Employee Health at [eh@visitphysicians.com](mailto:eh@visitphysicians.com). We look forward to working with you.

Employee Health Team

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**HIPAA COLLABORATIVE OF WISCONSIN**  
**AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION**

**[Individual/Patient/Client/Insured]:**

\_\_\_\_\_  
Name of Individual/Previous Names

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip, Phone (\_\_\_\_\_) \_\_\_\_\_

**AUTHORIZES:**

**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**

\_\_\_\_\_  
Individual(s)/agency/organization making disclosure

\_\_\_\_\_  
Individual/agency/organization receiving information

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

**INFORMATION TO BE USED &/or DISCLOSED:**

**[Implementation Tip—insert check boxes for specific types of information; e.g. progress notes, lab, claims history]**

The following is a specific description of the health information I authorize to be used and/or disclosed \_\_\_\_\_

In compliance with WI Statutes, which require special permission to release otherwise privileged information please release records pertaining to:  
[Check all that apply]

- Mental Health       Developmental Disabilities       Alcohol &/or Drug Abuse       HIV test results
- Other (Specify): \_\_\_\_\_

For the Following Date(s): From \_\_\_\_\_ To \_\_\_\_\_.

**PURPOSE FOR NEED OF DISCLOSURE:** (Check applicable categories)

**[Implementation Tip—insert check boxes for specific purposes; “at the request of the individual” is sufficient]**

- Further Medical Care       Coordinating Care for Dependent/Spouse       Insurance Eligibility/Benefits       Claims Resolution
- Other (Specify): \_\_\_\_\_

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

**Right to Receive Copy of This Authorization** - I understand that if I sign this authorization, I will be provided with a copy of this authorization. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that [the covered entity] may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party. **[Implementation Tip—identify applicable a-c and delete unnecessary provisions OR state the consequence if the individual does not sign—note, WI law requires the patient's authorization to disclose 252.15 or 51.30 records for payment purposes.]**

**Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to [Enter disclosing covered entity contact]. I am aware that my withdrawal will not be effective until received by [Enter disclosing covered entity name] and will not be effective regarding the uses and/or disclosures of my health information that [Enter covered entity name] has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. **MARKETING:** I understand if the [Enter covered entity name] uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. **[Implementation Tip—only needed if authorization is for marketing]** **Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) 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 [Enter name of department/individual].

**HIV TEST RESULTS:** I understand my HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request. **[Implementation Tip—if list is available with authorization, remove "upon request."]**

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**HIPAA COLLABORATIVE OF WISCONSIN**

**REDISCLASURE NOTICE:** I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

**EXPIRATION DATE:** This authorization is good until (indicate date or event) \_\_\_\_\_. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
*(If signed by other than individual, state relationship with signature)*

[Implementation Tip— insert check boxes to indicate legal relationships]

**This authorization is prepared in conjunction with the HIPAA-COW Authorization/Informed Consent for Use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.**

Prepared by: Susan Manning, JD, RHIA  
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Date: 02/20/03, 2/23/06

## Appendix B - Latex Allergy Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Job Title: \_\_\_\_\_

1. Have you ever had an anaphylactic reaction to latex devices/products? Yes      No
2. Have you ever been told by a doctor that you have an allergy to any latex product? Yes      No  
If yes, to what specifically did the doctor say you were allergic to? \_\_\_\_\_
3. Have you had a reaction to the following personal sources of latex?
  - a. Balloons  
Yes      No
  - b. Rubber gloves  
Yes      No
  - c. Hot water bottles  
Yes      No
  - d. Rubber bands, balls  
Yes      No
  - e. Foam pillows  
Yes      No
  - f. Baby bottles, nipples  
Yes      No
  - g. Pacifiers, teething rings  
Yes      No
  - h. Belts, bras, suspenders  
Yes      No
  - i. Latex birth control devices  
Yes      No
  - j. Erasers  
Yes      No
  - k. Face Masks  
Yes      No
  - l. Elastic bandages  
Yes      No
  - m. Cuffs, elastic waist bands  
Yes      No
  - n. Ostomy bags  
Yes      No
  - o. Shoes or other footwear  
Yes      No
  - p. Other: \_\_\_\_\_
4. After handling latex products, have you experienced any of the following:
  - a. Difficulty breathing: Yes      No
  - b. Runny nose/congestion: Yes      No
  - c. Itching hands or eyes: Yes      No
  - d. Hives: Yes      No
  - e. Redness: Yes      No
  - f. Cracking or chapping hands: Yes      No
  - g. Swelling: Yes      No
  - h. Other: \_\_\_\_\_
5. Do you have allergies to any of the following:
  - a. Bananas: Yes      No
  - b. Avocados: Yes      No
  - c. Potatoes: Yes      No
  - d. Tomatoes: Yes      No
  - e. Poinsettia: Yes      No
  - f. Kiwis: Yes      No
  - g. Chestnuts: Yes      No
  - h. Peaches: Yes      No
  - i. Papaya: Yes      No
  - j. Other: \_\_\_\_\_