Rockhill
ORTHOPAEDIC SPECIALISTS

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Number of Forms _____

Total Due $ _____

Prepayment Received?
Yes No

DISABILITY/FMLA FORM

There is an administrative **charge of $25.00** for the completion of **each** Disability/FMLA form. Pre-payment is required. Disability/FMLA forms are only completed for patients currently under active treatment. Your forms will be completed in seven (7) to ten (10) business days of receipt.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

E-mail Address: _____ **Phone:** _____

Physician: _____ **First day off work?** _____ **Anticipated return to work date?** _____

If so, when do you anticipate this? _____ **When do you anticipate returning to full duty?** _____

Are you treating under a workers comp claim? Yes or No

If you are not off work please explain the need for completing this form (IE: flareups, time off for treatment, etc.)

_____

_____

_____

I authorize Rockhill Orthopaedics to release the completed form(s) and/or the use and disclosure of any individually identifiable health information to:

Name/Organization: _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Fax:** _____

How information is to be released:

☐ **I would like the form(s) faxed to: Fax:** _____ **Attn:** _____

☐ **I would like the form(s) mailed to my home address.**

☐ **I would like to pick-up the form(s). Please call me when my form(s) are completed.**

Other: _____

By signing this authorization form, I understand that:

Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. Any disclosure carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. I understand that the information in my medical record may include information relating to mental health-care, communicable disease, HIV/AIDS and or treatment of alcohol/drug abuse. Unless otherwise revoked this authorization will expire in 1 year.

Patient/Authorized Representative Signature: _____ Date: _____ Time: _____

Printed name of authorized representative: _____ Relationship to patient: _____

Witness Signature: _____ Date: _____ Time: _____

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.