Disability/FMLA Form Request

Today's Date _____ **Received by (Initials):** _____ (*OAM use only*)

ORTHOPAEDIC ASSOCIATES OF MICHIGAN

1111 Leffingwell, NE, Grand Rapid, MI 49525
PHONE: (616) 459-7101 / FAX: (616) 336-5042

There will be a 7-10 business day processing time frame, as well as a processing fee based on the type of form. We understand you may have an urgent deadline for your paperwork and will do our best to accommodate you; however all paperwork will be processed in the order that we receive it without exception. By law, we are required to have you provide us with a signed authorization to disclose your information.

SECTION 1:

Patient's Name (First, Middle Initial, Last) _____

Date of Birth _____ **Daytime Phone #** _____

Email Address _____

Mailing Address (Street, City, State, Zip) _____

SECTION 2:

Purpose of disclosure (Check All That Apply): □ **Disability Forms** ($20.00) □ **FMLA Forms** ($20.00)

Fax or Mail completed forms to *(MUST BE COMPLETED by Patient)*

Name of Company/Person to receive completed forms: _____

Fax Number of Company / Person to receive completed forms: (_____) _____ -- _____

Address to send completed forms to (if NOT being faxed): _____

Attach this form to the document to be completed for disability determination

SECTION 3:

I authorize Orthopaedic Associates of Michigan to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition. I understand this may include: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions. I also acknowledge I am responsible to pay the form completion fee as set in state statutes prior to form completion.

- This authorization will expire one year from the date your signature below, unless you specify an earlier termination date. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than one year from the date of execution of this document: _____
- You have the right to revoke or terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____

Patient or Representative Signature Date

_____

Printed Name Relationship ("Self" or Authorized Representatives Only*)

*Legal paperwork for authorized representatives, including biological/adoptive parents, legal guardians and medical powers of attorney, must be on file.