Orthopaedic Associates of MICHIGAN

OAM Fax # 616-336-5042

Disability/FMLA Forms Request

COMPLETE ENTIRE FORM

Patient Name _____ Date of Birth _____

Address _____ Day Phone _____

OAM Provider _____ ***If FMLA** *(select one)* ○ **Intermittent** ○ **Continuous**

Release Completed Paperwork To: *(required)*

Name _____

Address _____

_____

Fax# _____ Claim # _____

Ciox partners with OAM and is pleased to assist you in completing your Disability and FMLA paperwork. **Be advised there is a 7-10 business days processing time frame once all information and payment is obtained.** We understand you may have an urgent deadline for your paperwork and we will do our best to accommodate this. However, all paperwork will be processed in the order that it is received. By law, we are required to have you provide us with a signed authorization which gives us permission to disclose your personal health information, which also serves as a guide of where to submit your paperwork. By completing this form, you are authorizing disclosure of your private health information.

I authorize Orthopaedic Associates of Michigan & River Valley Orthopedics 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; any condition, treatment, or therapy related to substance abuse; 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 paperwork completion fee prior to its completion.
- This authorization will expire one year from the date signed, unless an earlier termination date is specified. A new authorization must be submitted after the expiration date to continue authorization. *Please list date of expiration if less than 1 year*_____
- You have the right to revoke or terminate this authorization at any time by submitting a written request. Termination will take place upon written notice except where a prior authorization has 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 recipient listed to receive your protected health information. Therefore, your PHI disclosed under this authorization may no longer be the responsibility of the practice.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____

Printed Name Relationship

Office Use Only:

*Received By Initials*_____

☐ *Payment Collected* ☐ *N/A*

07/2021