Disability/FMLA Intake Form and Authorization

<u>FORM MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE ACCEPTED</u>

Patient Information:

Full Name: ____________ DOB: ____________ SSN: XXX-XX-____

Address: ____________

City: ____________ State: ____________ Zip: ____________

Phone #: ____________ Email Address: ____________

Release Information To:

Name of Person/Organization: ____________ Phone: ____________

(Example: Employer, Disability Carrier, Auto Carrier, etc.)

Please check one

☐ Mail to Address: ____________

City: ____________ State: ____________ Zip: ____________

☐ Fax #: ____________

☐ Call to Pick Up: ____________

Treating physician's name:

Time off is: (Circle one)

Intermittent or **Continuous**

Additional information:

If you **DO NOT** want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Signature

I hereby authorize Michigan Orthopaedic Surgeons, PLLC and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, unless otherwise noted. This authorization is valid for 1 year from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and therefore the privacy of personal and health information is no longer protected by HIPAA. I acknowledge that Michigan Orthopaedic Surgeons, PLLC or its affiliates reserve the right to charge for processing and copying information.

Signature: ____________ Date: ____________

(Patient, parent of minor, legal guardian, personal representative or person with authority)

Name and Relationship (if other than patient): ____________