SOUTHWEST ORTHOPAEDIC SPECIALISTS

FMLA-STD FORMS INFORMATION

NOTE: There is a $35.00 charge for completion of medical forms that must be paid in advance.

PLEASE FILL IN ALL INFORMATION COMPLETELY AND ACCURATELY

PATIENT NAME: _____DOB:_____

PATIENT ADDRESS:_____

PATIENT PHONE: _____SSN:_____

TREATING PHYSICIAN:_____

WHERE DO YOU NEED THE FORMS TO GO TO:

COMPANY NAME:
ATTENTION:_____PHONE:_____

FAX:_____

ADDITIONAL INFORMATION NEEDED:_____

WORK RELATED INJURY? YES / NO

Please choose from the following:

1. Continuous Leave Start Date: _____

Projected Return to Work Date: _____

2. Intermittent Leave Start Date: _____

If you have been told not to return to work by your doctor or have been scheduled for surgery, what is the first date of work that you missed or will miss? _____

By signing below, I hereby give Southwest Orthopaedic Specialists authorization to process payment and send appropriate medical information to the above-named entity.

Patient/Advocate Signature:_____ Date:_____

SOUTHWEST ORTHOPAEDIC SPECIALISTS

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____Date of Birth: _____
Phone:_____Social Security Number: _____

I hereby authorize Southwest Orthopaedic & Reconstructive Specialists to release the following information to:

Name of Person/Organization Receiving PHI:
Phone: _____ Fax:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Information to be shared:

- Progress Notes☐ Procedure Reports ☐ Radiology Reports ☐ Entire Medical Record
- Medical information compiled from _____ to_____ (insert dates)

The information may be disclosed for the following purpose(s) only:

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis,

syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

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Signature of Patient or Legal Representative:_____Date:

Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

Delivery/format: ☐ US mail ☐ Will pick up ☐ Fax

☐ email: _____

If you prefer email, please provide the email address above.

* Please mail or fax the completed Authorization form to SOS at the address or fax number listed below:

Email address: SOSFMLA@ southwestortho.com

Fax: 405-632-4317

HIPAA Document – retain for a minimum of 6 years