Date: __ __/__ __ /__ __ __ __

Account #_______________

Request for Form Completion

Privacy Office: 4601 Park Road Ste. 250 Charlotte, NC 28209 Ph. 704-323-2049 / Fax: 704-323-3954

Pre-Payment is Required. Please allow 7-10 business days for completion of forms(s).

FOR OFFICE USE ONLY

Please check form type:

☐Disability / 99080D $20.00 **each** ☐FMLA / 99080F $20.00 **each**

Total Due: ____________ **Payment Received by:** _____________________________ **Physician #:**____________

Physician Location Code:____________

Payment Method: ☐Cash ☐Check #_______ ☐Credit Card #______ /______/______/______ Exp: _______CVV Code:____

Type: ☐Visa ☐Mastercard ☐Discover ☐American Express ☐**PAYMENT NOT RECEIVED**

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member

Patient Name:____
(Last) (First) (Middle / Maiden)

Address:____

City:__________________________________ State:_______________ Zip:__________________

Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Cell/Work #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Physician:___________________ Date Injury/Problem Began:________________
Last Day Worked:_________________

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:________________
Please check a reason: ☐Continuous Leave ☐Surgery and Post-Op Treatment ☐Intermittent Leave
For Family Members requesting leave, what date(s) do you anticipate being out of work:___________________________

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

Name/Organization:____
(i.e. Self / Family Member / Insurance / Employer

Address:____

City:__________________________________ State:_________ Zip:__________________

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Fax #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Please check your preferred method of release:

☐ Mail the form to the patient's address ☐ I will pick-up the form ☐ Fax the form to number provided
☐ I will have someone pick-up the form for me ☐ Mail the form to the name/organization above
Individual's Name: _______________________ Relationship: ☐ Spouse ☐ Parent ☐Child ☐ Other_____________

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the OrthoCarolina Privacy Office and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by OrthoCarolina before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS.

This authorization will expire in 1 year or when I am released from my treating provider at OrthoCarolina.

Signature:____ Date:________________
(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:____________________)

OrthoCarolina Tax I.D.# 56-1093722