Date: __ __/__ __ /__ __ __ __ OrthoCarolina Account #_____

Request for Form Completion
Privacy Office: 4601 Park Road Suite 250 Charlotte, NC 28209 - Phone 704-323-2049 / Fax 704-323-3954
Email: OrthocarolinaPrivacy@orthocarolina.com

Payment is Required. Please allow 14 days for completion of form(s).

FOR OFFICE USE ONLY

Please check form type: ☐ Disability / 99080D $20.00 **each** ☐FMLA / 99080F $20.00 **each**

Total Due: _____ **Payment Received by:** _____ **Location:** _____

Payment Method: ☐Cash ☐Check #_____ ☐Credit Card ☐ PAYMENT NOT RECEIVED

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_____

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

Address:_____

City:_____ State:_____ Zip:_____

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

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

Physician:_____ **Body Part:**_____

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:_____

Address:_____

City:_____ State:_____ Zip:_____

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

Email Address: _____

Please check your preferred method of release:
☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above
☐ I would like to pick up the form. Please call #___ ___ ___/___ ___ ___/___ ___ ___ ___ when form is ready.

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

Revised: 11/2020