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

Pre-Payment is Required. Please allow 7-10 business 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: _____ 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-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 #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Please check your preferred method of release:

☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above
☐ I will pick-up the form at Location:_____
☐ I will have someone pick-up the form for me: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

Revised: 11/11/2015