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

Request for Form Completion

Phone: 866-273-4039 | Fax: 866-570-0729 |

To submit an FMLA or Disability form for completion, please visit the link below

orthocarolina.com/patient-forms

Pre- Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s). The fee schedule is as follows: **$30 for initial form, $15.00 for updates for same qualifying condition, plus any applicable sales tax.** You will be contacted by Sharecare with payment options after you return this paperwork.

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 #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address(*Required)-:_____

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 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:_____)

Revised: 6/2021