



Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Request for Form Completion

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

**Pre- Payment is Required. Please allow 2-3 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:

**\$25 for initial form and 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: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

**If I do not specify expiration this authorization will expire in 90 days.** If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. \* \_\_\_\_\_ (Please Initial)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Authorized Representative – Relationship: Spouse Parent Other: \_\_\_\_\_)