FMLA and Disability forms

Print the FMLA/Disability Information Sheet and the Authorization form

Complete the Information sheet. Please be as detailed as possible when completing the Information Sheet which will allow our staff to complete your paperwork within the 7-10 business day timeframe.

Fill out the Authorization form with regard to where you want your form mailed/faxed to, sign and date. The authorization form is good for one year.

Complete your portion of your FMLA/Disability forms

Bring the FMLA/Disability forms along with the FMLA/Disability Information Sheet and Authorization form to any one of our Jewett Orthopaedic Clinics along with your $25.00 fee. The Front Desk Team will scan your information into the computer and send to the Administrative Assistant who works with your provider. Please remember that there is a 7-10 business day turnaround time to complete the forms. If you have any questions, please do not hesitate to contact the Administrative Assistant working with your provider

DISABILITY/FMLA FORMS

There is a $25.00 fee for each form to be paid prior to completion of forms.

Patient Name _____ Patient account no._____

Patient phone no. _____ Alternate no. _____

Treating physician _____ Body part _____

Occupation/Employer _____

_____

What work activities are you unable to do?_____

_____

_____

Last Date Worked_____ Return to Work date_____

Instructions (fax or mail to patient; pick up by patient): _____

_____

_____

Please allow 7-10 business days for completion of forms.

Authorization form needs to be completed to release information for FMLA/disability forms.

Payment received _____

JOC employee _____ Date _____

Please scan into patients chart and forward to patient forms pool

NAME _____ DATE OF REQUEST_____

DATE OF BIRTH _____ ACCOUNT # _____

JEWETT ORTHOPAEDIC CLINIC
AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

As a patient or as an authorized representative of a patient of Jewett Orthopaedic Clinic, you are entitled to a copy of your medical records. You may also authorize release of your medical records to other recipients. You understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. When received by the medical records personnel, your identity will be verified and your request will be processed. If you have any questions or concerns, please contact the Director of Medical Records at 407-643-1286.

☐ I would like a **copy** of my medical records. I understand there may be a fee for these copies including any applicable postage fees. I understand that I will be required to pay the fee(s) in full before I may obtain the copies.

☐ Please send copies of my medical records to: ☐ By Mail ☐ By Fax ☐ Will Pick Up

Name _____ Phone#_____

Address _____ Fax# _____

_____ Pt. Phone# _____

Description of Information to be copied (check all that apply)

Medical data/information as related to:

- ☐ Specific condition(s) /specific physician(s):_____
- ☐ Specific time frame(s):_____
- ☐ All office notes, test results, and/or operative reports:_____
- ☐ Other:_____

Reason for request: ☐ Legal ☐ Insurance ☐ Medical Treatment ☐ Other_____

This authorization expires on [upon] _____ [Insert applicable date or event, i.e. - completion of treatment for this medical condition]

I understand that I may inspect or obtain a copy of the information used or disclosed.
I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:

1. **Action has been taken in reliance on the Authorization; or**
2. **If this Authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.**

By signing below, I acknowledge and agree to the above conditions.

DATE _____

_____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) **PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)**

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

_____

FOR OFFICE USE ONLY

Identity Verification: ☐ Driver's license ☐Other ID # of Copies _____ @ $ _____ per copy $ _____ Total Cost

☐ Date Picked Up _____.☐ Date Faxed _____ ☐ Date Mailed _____ ☐Entered in Correspondence Log