



**ORTHOPEDIC
PARTNERS**

Disability / FMLA Release Form

Patient Name _____

DOB _____

I hereby authorize Orthopedic Partners to release my disability/FMLA forms as well as any records needed to support my claim to: (please select either fax or mail)

Company/Carrier Name: _____

Fax number for records: _____

Alternate Fax number (if applicable): _____

Address (if forms/records are to be mailed)

I understand that by declining to sign this release, my forms and the associated records (if applicable) will be delivered encrypted to the email address on file or the home address of the patient if no email is available. I may also elect to pick up the completed forms at the selected office below or have them mailed to me. (please select one)

- North Franklin
 - Niantic
 - Mail
 - Email (please confirm address)
-

This release shall be effective for **6 months** or **1 year** from the date of my signature. I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office of the above-named facility authorized to make this disclosure. I understand that the revocation does not apply to information already released in response to this authorization. I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to ensure continued treatment. I understand that if I have questions about disclosure of my health information, I may contact the privacy office at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

My evaluation, diagnosis, and / or treatment relating to the conditions listed below may be released to the requestor identified above for the following type of records unless otherwise indicated.

Agree Disagree - AIDS or HIV

Agree Disagree - Psychiatric care and / or psychological assessment

Agree Disagree - Treatment for alcohol and / or drug abuse

Agree Disagree - Mental health treatment

Failure to complete the above selections will automatically imply a declination of the above

Requests cannot be processed without proper authorization. Minors must have a parent's signature. Individuals requesting records on adult patients must provide the required Power of Attorney or other supporting legal documents.

Patient Signature _____ **Date** _____