ORTHOWEST

TOTAL ORTHOPEDIC SOLUTIONS

FMLA / DISABILITY REQUEST FORM

150 Clinic Ave, Suite 101 **Phone 770.834.0873**
Carrollton, GA 30117 **Fax 770.834.6118**

Patient Information

Patient Full Name: ____

Date of Birth: _______________ Phone Number: __________________SS# (last 4 digits)_____________

Patient Address: ____

City: ____________________________ State: ____________ Zip Code: _________________________

Email Address: ____

What doctor is treating you for this issue?_____________________

Where do you want the form sent after completion? Complete info below

Email Address: ____

Name: _____________________________________ Attention:____________________________

Address: ____

City: ____________________ State: ______ Zip Code: ____________Fax:______________________

Purpose: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer of Care ☐ Other __________________

Information to be Released

___I authorize the release of supporting medical records to supplement leave claim.

___I am requesting leave starting ____________.

___I am requesting intermittent leave.

Reason: _______________________

Frequency:______days per week _______month

Cost: $80.00 for completion of your first form. $40.00 for each additional form.

Payment is required before release of form.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that: 1) I may refuse to sign this authorization and that it is strictly voluntary, 2) My treatment, payment, enrollment or eligibility for benefits may be conditioned on signing this authorization. 3) I may revoke this authorization at in 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 one (1) year). 4) 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. 5) 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.

Signature: ____ **Date:** _______________

Credit Card Authorization

Cardholder Name_______________________

Address______________________________

City_________________State____Zip________

Credit Card Information

Card Type: Visa MasterCard AmEx

Card Number___________________________

Exp Date__________Security Code____________

Signature______________________________