1765 Old West Broad Street, Bldg 2

Athens, Georgia 30606

706.549.1663

Date: _____ Employee:_____

Pymt:_____ Amount: _____

Account #: _____

DISABILITY/FMLA FORMS

FULL NAME: _____ PATIENT DOB: _____

SOCIAL SECURITY: _____ CONTACT PHONE: _____

******PLEASE NOTE WE HAVE 7-10 BUSINESS DAYS TO COMPLETE YOUR FORMS******

PATIENT INFORMATION:

BODY PART in which disability form is for:

_____

APPROXIMATE dates for disability (discussed with your provider):

_____

FEE:

FORMS: $20 per physician signature

***Forms will **NOT** be completed without a payment up front.

This only prolongs the process of completing your forms.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that your facility may have a fee for medical records in accordance with the State law. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at 1765 Old West Broad St, Bldg 2, Ste 200, Athens, GA 30606, by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committee. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize ***ATHENS ORTHOPEDIC CLINIC, P.A. & GEORGIA SPORTS MEDICINE INSTITUTE*** (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

_____

Signature of Patient

_____

Printed (legible) Name of Patient

_____

Date Signed

*****Forms will be completely in the ORDER they were received, due to the high volume of forms that are received daily.**

I WOULD LIKE MY FORMS:

- ☐ **Mailed to my address on file.**
- ☐ **Faxed to: _____**
- ☐ **Pick up at Athens Orthopedic Clinic Urgent Care (Athens) location**
- ☐ **Pick up at Athens Orthopedic Clinic Monroe location**

*****If picking up forms, please provide best number you can be reached: _____**

Addresses for all locations can be found on our website, www.athensorthopedicclinic.com