

**Athens Orthopedic Clinic, P.A.**

1765 Old West Broad Street

Athens, GA 30606

706.549.1663

**DISABILITY/FMLA FORMS**

FULL NAME: _____	PATIENT DOB: _____
SOCIAL SECURITY: _____	CONTACT PHONE: _____

**\*\*\* PLEASE ALLOW 7-10 BUSINESS DAYS TO COMPLETE YOUR FORMS \*\*\***

<b><u>FORM INFORMATION</u></b>
<b>BODY PART</b> in which disability form is for: _____
<b>APPROXIMATE</b> dates for disability (discussed with your provider) _____

<b><u>FEE:</u></b>
FORMS: \$20 per form/physician signature <b>***Payment is required in advance.</b>
Forms will NOT be completed without prior payment.

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 Practices' 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. ("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 Name of Patient:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**(Completed form will be emailed to you)**

<b>I WOULD LIKE MY FORMS:</b>	
_____ Mailed to my address on file	
_____ Faxed to: _____	
<b>I WILL PICK UP AT Athens Orthopedic Clinic:</b>	
___ Athens Main Office	___ Urgent Care
___ Monroe	___ Loganville
___ Snellville	___ Covington
___ Greensboro	Other: _____

\*\*\* If picking up forms, please provide the best number you can be reached at: \_\_\_\_\_

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

**Addresses for all locations can be found on our website: [www.athensorthopedicclinic.com](http://www.athensorthopedicclinic.com)**

Date: _____	Payment Type: _____	Credit _____	Cash _____	Check (Check #: _____)
Amount: \$ _____				
Account #: _____				
Employee Name: _____				