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 ******

FORM INFORMATION

BODY PART in which disability form is for:

_____

APPROXIMATE dates for disability (discussed with your provider)

_____

FEE:

FORMS: $20 per form/physician signature
*****Payment is required in advance.**

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)

I WOULD LIKE MY FORMS:

_____ Mailed to my address on file
_____ Faxed to: _____

I WILL PICK UP AT Athens Orthopedic Clinic:

___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

Date: _____ Payment Type: _____Credit _____Cash _____Check (Check #:_____)

Amount: $_____

Account #: _____

Employee Name: _____