FMLA / Disability / School, Work, Insurance Paperwork

It is our office policy to charge for the completion of paperwork for the Family Medical Leave Act (FMLA), long-term care, life insurance, the Department of Veterans' Affairs, disability claims or forms for other purposes. Our standard fee ***includes one-time completion/submission of such form.*** After the form has been completed and submitted, if updates or more information is necessary, an additional fee *may* apply. — Form completion and processing fees range from $10/ $25 based on the number of pages included per form.

We will complete the form and return it to you within 5 – 10 business days from the receipt of payment.

We cannot fax these forms without written authorization from you for us to do so!

To avoid delays, please return the form with payment and a signed release of information (below) to the third party to whom you want the form/information sent. If the form to be completed was sent to us by an organization, we will notify you of the exact amount that is due. (To limit what is disclosed, please make sure that you fill out the condition and/or indicate start and end dates.)

Finally, completion of certain forms, such as return-to-work forms or disability determinations, etc., may require an update of your medical information or a special examination. In such cases, you will be asked **to make an appointment** and we will fill out the form as part of the office visit without extra charge.

If the forms are for are for a family member of the patient (ie: husband, child or parent) to care for the patient, please specify the amount of time needed.

If you have any questions, please ask one of our staff members.

Thank You,
P&S Clinic Administration

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO THIRD PARTIES

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ______________________________ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State ________ Zip Code: ____________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ All healthcare information DATES: ____

☐ Other: DATES: ____

CONTINUED NEXT PAGE

If requesting records to be faxed to third party, you must do so in writing below. You must also sign next to your request!

____

By signing this authorization, I authorization, I authorize Physicians and Surgeons Clinic, PLLC to use and or disclose certain PHI about me to or for the party or parties listed above. When my information is used or 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.

If the forms are for are for a family member of the patient (ie: husband, child or parent) to care for the patient, please specify the amount of time needed below.

____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________

Witness: ______________________

THIS AUTHORIZATION WILL EXPIRE ON:__________________________.

IF NO DATE WRITTEN, THE AUTHORIZATION WILL EXPIRE AFTER 90 DAYS.

This authorization regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in this authorization. Please note that we are required to retain records of your care.

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