FORIS SURGICAL GROUP, LLP
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

INDIVIDUAL'S NAME: _____ **DATE OF BIRTH:** _____

INDIVIDUAL'S ADDRESS _____

I hereby authorize Foris Surgical Group, LLP and its subcontractors to disclose protected health information about me to:

Name: _____

Address: _____

Phone Number: _____ Fax Number (as needed): _____

The specific information that should be disclosed is (please give dates of service if possible):

[__] Office Notes(s) _____
[__] Pathology Report(s) _____
[__] History & Physical Exam(s) _____
[__] EKG/Cardiology Reports _____
[__] Hospital Discharge Summary _____
[__] Complete Medical Record
[__] Operative Report(s) _____
[__] Lab Test Results _____
[__] Radiology Report(s) _____
[__] Form Completion _____
[__] Other _____
_____

The purpose for this disclosure is:

[__] "At the request of the individual" _____
[__] Disability or other insurance claim _____
[__] Application for insurance policy _____
[__] Upcoming Appointment with Medical Provider
[__] Family & Medical Leave Act (FMLA) Request
[__] _____

1. I understand that the information to be released may contain information related to HIV status, AIDS, hepatitis, sexually-transmitted diseases, pregnancy, alcohol use, drug use, or mental health services, and I hereby authorize the release of this information.
2. I understand that there is the potential for the disclosed information to be subject to redisclosure by the recipient and it would then no longer be protected by federal privacy regulations.
3. I may revoke this authorization by notifying Foris Surgical Group's Privacy Officer in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that Foris Surgical Group, LLP may not condition its treatment of me on whether or not I sign an authorization. An exception is when the service is provided at the request of a third party solely for the purpose of creating the information to disclose to that third party (for example, an Independent Medical Exam).
5. This authorization for disclosure expires one (1) year from the date of the signature below, unless revoked prior to that date.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. We have contracted with Smart Corporation to make copies. You may be required to prepay for the copies. If not your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED, SIGNED & DATED TO BE A "VALID" AUTHORIZATION UNDER CFR 164.508.

_____	_____	_____
Signature of the Individual (Patient)	Date of Individual's Signature	Date of Birth or Social Security Number

OR, if applicable –

_____	_____	_____
Signature of the Individual's Guardian or Personal Representative	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual

A SIGNED COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE Individual or other signer to comply with Federal Law. (CFR 164.508)

Foris Surgical Group, LLP
PROCEDURE FOR DISABILITY CLAIMS, F.M.L.A. REQUESTS, & OTHER EMPLOYER FORMS

****NOTICE - Effective 11/1/2013, there is a *$25.00 fee for completion of any forms other than* our standard Return to Work/School Slip (this will be provided at no charge).****

1) A completed & signed HIPAA Authorization to Disclose Protected Health Information is required in order for us to complete any employer-required form, disability claim form, or Federal FMLA (Family & Medical Leave Act of 1993) form. This must be completed by the **patient**.

2) In advance of your surgery:

a) Request the HIPAA Authorization to Disclose Protected Health Information form from our office.

b) Contact your employer or HR Dept. to determine their requirements for your absence from work. Complete any Employee sections of their form(s) **before** you give them to us.

c) Return the Authorization form, forms from your employer, and the $25.00 fee (per form) to our office before surgery.

3) Advise us as to how you wish to have the forms returned. (For example, pick-up, mail, fax to employer/disability carrier, etc.)

Also provide any information discussed with your surgeon as to how long your absence from work is anticipated to last.

4) Allow 5 days for forms to be completed. (Our clinical staff is involved in many other tasks, and your surgeon is not in the office every day.)

5) Please Note: If the dates of your anticipated absence are left blank, the date will be filled in by the clinical staff for the surgeon to approve. If anticipated dates are not justifiable, you will be notified before your form is completed.

I have read the above and agree to the $25.00 fee for completion of each form by the surgeon. I anticipate being absent from work
from _____ through _____,
with a return to work date of _____.

When completed, please:

[__] call me to pick up my form. Phone#_____
[__] fax it to _____ Fax #_____
[__] mail it to: _____

_____ _____
Signature/Print Name Date