TEXAS ORTHOPEDICS
SPORTS & REHABILITATION ASSOCIATES
A DIVISION OF OrthoLoneStar

FMLA / Disability Form Authorization

Patient Name: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Completed Forms to be delivered to:

_____ **Patient (to address above)**

_____ **Third Party:** _____

Claim #: _____ **Fax #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

- **Anticipated Date to Leave Work:** _____
- **Anticipated Return to Work Date:** _____
- **What is your job title?:** _____
- **What are your job requirements? (Or please provide a copy of your job description):**

  _____

  _____

I authorize Texas Orthopedics to release medical information to insurance carriers regarding disability claims.

I understand that:

- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I can request a copy of this form after I sign and date it.

Signature: _____ **Date:** _____

This authorization expires 180 days from the date of signature.

Once we receive your form(s) and the signed authorization, please allow 7-10 business days for completion.
A $40 fee per form is due prior to release of completed forms payable by cash, check, or credit card.*
All completed forms will be faxed to the employer/disability carrier as indicated by the patient or may be picked up from our office.
**There is a $50 fee for STAT (24-48 business hours) and requests and $5 per page after 5 fillable pages per form*