Dear Patient,

Thank you for contacting **Tidewater Orthopaedics** Release of Information Department. We are here to serve you and your health information needs.

For FMLA or disability leave paperwork, please complete the enclosed authorization form and attach your blank forms for completion.

- Please make sure you have *specific* instructions included as to where you are requesting the forms to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of Tidewater Orthopaedics.
- You may elect to have completed forms emailed, mailed, or faxed to the recipient listed. **It is recommended that you elect to receive your forms back via email.**
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/disability leave claim.** This means records may be attached to the forms that are being completed and will be released as indicated on the authorization.

Return the completed release and blank FMLA/Disability forms to:

Fax: 757-827-2566

Mail: **Tidewater Orthopaedics**
Attn: Medical Records/ROI
901 Enterprise Pkwy, Ste 900
Hampton, VA 23666

A fee of $25.00 per form is required prior to form completion. For updates regarding the same qualifying condition and claim, updates are completed at no cost, up to 90 days after initial request. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider.

Once payment is received, your form will be completed and sent to the recipient listed on your release. For questions pertaining to FMLA or disability leave paperwork, please contact Sharecare Health Data Services at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of Tidewater Orthopaedics

sharecare | HEALTH DATA SERVICES

Tidewater Orthopaedics
Specialized Care You Can Trust

AUTHORIZATION TO RELEASE PHI : FMLA/Disability Request

*The undersigned authorizes **Tidewater Orthopaedics** to release my health information as noted below.*

Phone 757-827-2480 | Fax 757-827-2566

*Patient Information *Please Print**

Patient Full Name: ____________________________ **Date of Birth:** _____________ **Other Names?** _______________

Patient Address: ______________________________________ **Phone #:** __________________ **SS#** (last 4 digits)________

City: ____________________ **State:** ______ **Zip:** ___________ **Email:** ____

Doctor completing Form

Doctor: ____

Where do you want the form to be sent after completion?

If you have multiple forms, you will need to complete a release for each recipient who needs a copy of the form.

Purpose of Request: ___ FMLA Leave ___ Short Term Disability ___Other

Company: ____ **Attention:** ____________________________________

Fax to: ______________________________ **Email to:** ____

Mail to: ____ **City:** ___________________ **State:** _____ **Zip:** _________

For questions call: ____ **This leave is for:** ☐ **Myself** ☐ **My Caregiver**

Information to be Released

By signing this form, I am requesting the attached form(s) to be completed and sent to the recipient listed. I further authorize the release of supporting medical records to supplement my leave claim to be released.

___ I am requesting leave starting: ____________________
(1st day of Leave)

FMLA/Disability Forms Completion:

A fee *per form* is due prior to completion of the form(s). The fee schedule is as follows:
A fee of $25.00 per form is required prior to form completion. For updates regarding the same qualifying condition/claim, updates are completed at no cost, up to 90 days after initial request.
You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* ___________ (*Please Initial*)

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. 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. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ________________________**.** *If I do not specify expiration, this authorization will expire in 1 year.* 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.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:____ **Date:** __________________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*