STEINDLER
ORTHOPEDIC CLINIC
2751 Northgate Dr, Iowa City, IA 52245
(319) 338-3606 • Fax: (319) 338-0522

Staff Initials _____

Account # _____

STD/FMLA FORMS REQUEST

Steindler Orthopedic Clinic processes requests in the order they are received. In order to process your forms promptly and accurately, please complete all of the following information. All Forms will be filed in the patient's chart as part of the patient's medical record.

PLEASE ALLOW UP TO 10 BUSINESS DAYS FOR THE COMPLETION OF ALL FORM REQUESTS.

Today's Date_____ **Steindler Physician or P.A.** _____

Patient Name _____ **Patient Date of Birth**_____

If the forms are for **someone other than the patient** please specify:

Name_____ **Relation to Patient** _____

Company/Employer_____

Describe injury or type of surgery _____

Date of Injury (if applicable?) _____ **First day of work missed** (if applicable)_____

Return to work date or estimate_____

Other information that may help us complete your paperwork _____

_____

How do you want your COMPLETED paperwork processed? (May check more than one box)

- ☐ Please fax to: _____
- ☐ I will pick up completed forms.
- ☐ Please mail to the Patient's address on file.
- ☐ Please mail in the envelope provided to:_____

To assist with any further questions, my phone number is _____

Type of form(s) to be completed:

- ☐ Disability* ☐ Continuation of disability
- ☐ FMLA ☐ Work Release ☐ Loan* ☐ Loan Continuation
- ☐ Accident/Injury ☐ Sickness ☐ Other _____

*A $20.00 service charge applies to Disability & Loan forms to assist with covering the costs of processing the form. These costs include but are not limited to: the time required to complete the form as well as the transmission of forms and medical records.

Internal Use: Check# _____ Cash _____ CC _____ Amount Paid $ _____

STEINDLER
ORTHOPEDIC CLINIC

Account # _____

AUTHORIZATION TO RELEASE INFORMATION

Please allow 7-10 Business Days to process

Patient's Legal Name (please print)**:** _____ DOB: _____

By signing this form, I allow Steindler Orthopedic Clinic (SOC) to release medical information concerning the above named patient to the following:

_____

Name of Person and/or Institution (Employer, Disability Insurance)

_____

Complete Mailing Address/Street/P.O. Box **City, State, Zip Code**

Please check the information to be disclosed:

☐ All medical & financial information necessary for the completion of the forms I have provided.

OR

☐ Other, specify _____

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial next to any category **NOT** to be released):

_____ Substance Abuse _____ Mental Health _____ HIV- related information

Indicate the reason for release:

☐ Disability/FMLA ☐ Other, specify _____

I understand that SOC will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form, except in the following situations:

• If the medical information to be disclosed will result from treatment for research purposes, SOC will not provide the treatment if I am unwilling to sign this authorization form.

• If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, SOC will not provide the treatment if I am unwilling to sign this authorization form.

I understand that I may revoke this authorization by sending a written request for revocation to SOC. If I revoke this authorization, SOC will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when SOC discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

This agreement will expire one year from the date of signature, unless canceled by the patient or patient representative.

_____ _____

Signature of Patient or Patient Representative **Date**

If signed by Patient Representative, print name and state the authority to act on behalf of the patient: _____