Request for Form Completion

Pre-Payment is Required

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_______________________________

Patient Name:____
(Last) (First) (Middle / Maiden)

Date of Birth:__________________________________ Telephone #: ____

Address:____

City:____ State:______________ Zip:_________________

Physician:___________________________________ Body Part:______________________________

Date Injury/Problem Began:____________________ Last Day to Work:_________________________

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_________________________

Please check a reason: ☐Continuous Leave ☐Surgery and Post-Op Treatment ☐Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work: FROM:___________TO:______________

Please allow 7-10 business days for completion of form AFTER PAYMENT RECEIVED.

I authorize Inov8 Orthopedics to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:____
(i.e. Self / Family Member / Insurance / Employer)

Address:____

City:_________________________________ State:_________ Zip:______________________

Telephone #:__________________________ Fax #: __________________________________

Please check your preferred method of release:

☐ Mail the form to the patient's address ☐ Mail the form to the name/organization above

☐ Fax the form to number provided above

☐ I will pick-up the form. **A representative from our office will contact you to coordinate a designated date & time to pick up forms*

☐ I will have someone pick-up the form for me: Name ___________________Relationship: ☐ Spouse ☐ Parent ☐Child ☐ Other

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying Inov8 and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Inov8 before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. *This authorization will expire in 1 year or when I am released from my treating provider at Inov8.*

Signature:____ Date:__________________________

Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_________________________

Please check form type: ☐Disability $25.00 **each** ☐FMLA $25.00 **each** ☐Postage $7.35

Payment Method: ☐Cash ☐Check #_______ ☐Credit Card #______ /______/______/______ Exp: _______CVV Code:_______

Name as it Appears on credit Card ______________________________ Mailing address for Credit Card ______________________________