Disability/FMLA Form Completion Instructions

If you are having surgery, you may have a disability policy to compensate you for the time you are anticipated to miss from work. Individuals related to the patient may also access benefits under the Family Medical Leave Act. In order to expedite any related requests, we will require the following:

1. The patient must sign the HIPAA release below.
2. If different from the patient, the individual requesting FMLA benefits must also sign a release of information.
3. A $25.00 fee must be paid, in advance, **PRIOR** to our completing this paperwork**.** ***This fee recurs every time we are required to verify an additional set of paperwork.***
4. Advise us of the date range you (or your family member) are anticipating to be off work. Please note that the date of disability determination is made **independently by the surgeon, subject to his/her medical opinion.** However, we are requesting, in advance, your expectations in this regard.
5. Disability/FMLA requests should be **initiated PRIOR to surgery**. You can have your forms faxed or emailed directly to your physician's medical assistant.
   Dr. Goldblatt: Fax to 602-252-6232 Attn: Luisa or email to Luisa.Ornelas@ACRSurgeons.com
   Dr. Brown: Fax to 602-252-6232 Attn: Lisa or email to ContactUs@ACRSurgeons.com
   Dr. Calcote: Fax to 602-252-6232 Attn: Lisa or email to ContactUs@ACRSurgeons.com
6. In the event subsequent disability forms require completion, the entire process repeats, however the signed authorization can be reused provided the dates of authorization cover the scope of the disability period.
7. Please **anticipate** your need, well in advance, for the completion of disability forms. Disability is entirely predictable and, with proper planning, the process should go smoothly.
8. Please allow at least 72 hours for our completion of these forms.

Authorization for Affiliated Colon and Rectal Surgeons, P.C.

Patient name: _____ Date of Birth: _____

Previous name: _____

I. My Authorization

You may disclose my health information to: FMLA / Disability Company / H.R. for my employer

II. My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment), except: to take part in a research study; or to receive health care when the purpose is to create health information for a third party. I understand that I may revoke this authorization in writing at any time. However, I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are: to fill out a revocation form available from the office; or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship