**Disability and Family Medical Leave Act release of Information**

Patient Name: Date of Birth:

Address: \_\_\_\_\_\_\_\_\_

City: State: Zip: Phone:

Contact Name (if different than patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body Part\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RELEASE DISABILITY/FMLA INFORMATION TO REQUESTING PARTIES:**

 **(Please allow 5 – 7 business days to complete)**

**FAX TO:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAIL TO: Name/Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CALL FOR PICKUP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_at: Westminster Golden Highlands Ranch**

 (Name, Phone number)(circle one)

**Mail** completed form back to Panorama Orthopedics; Attn: Disability/FMLA; 660 Golden Ridge Road; Golden CO 80401 *or* **fax** to: 720-497-6716.

**REVOCATION:** I understand I may revoke this authorization at any time in writing. Cancellation of this authorization does not apply to any records previously released in reliance of this authorization. For records to be release directly to the patient, an expiration date of “NONE” is acceptable. For all others, the maximum period for release of records without an updated authorization is one year. A copy of this form is as valid as the original.

I understand that once my information is released under this authorization, my physician(s) and their employees cannot prevent the re-disclosure of that information.

**AUTHORIZATION:** I authorize Panorama Orthopedics & Spine Center to release disability/FMLA information to the designated recipient.

Signature of Patient/Guardian Relationship to Patient

Today’s Date Reason Patient Unable to Sign