AUTHORIZATION FOR COMPLETION OF FORMS

PLEASE NOTE: All items must be completed to process your form.

Patient Name: ______________________________ Phone #:_______________ Date of Birth: _____________

I hereby authorize any and all treating physicians, nurses, social workers, etc., to release any and all information needed to complete this form.

1. When the form is complete (choose one):

- ☐ I would like to pick it up. Call me at: ______________________________
- ☐ Fax to (company name):______________________________________ Fax #: ___________________
- ☐ Send by Secure Email (print clearly): ____
- ☐ Send to my portal
- ☐ Mail to: ____

2. Reason for Form Completion – Please make sure the Employee Section is completed.

☐ **Off Work: If your specialist or surgeon took you off work, they will need to complete your form.**

List diagnosis/symptom: ____

Choose One:

Continuous leave – From: ______________ To: _________________ Return to work: _____________

Intermittent – Frequency: ____________ Duration: ______________

☐ **Leave to care for family member:** Family member name ____________________ (patient must sign below)

☐ **Work Accommodation:** Diagnosis ____

Requested Accommodation ____

☐ **Medication form** – list medication ____

☐ **Other type of form:** ____

3. **Fee:** For 1 form ☐ **$20** For 2 forms ☐ **$25** For 3 or more forms ☐ **$30** Paid _____ Due _____

I UNDERSTAND that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE INCLUDE: DIAGNOSIS, PROGNOSIS AND TREATMENT FOR PHYSICAL AND/OR EMOTIONAL ILLNESS, INCLUDING TREATMENT OF ALCOHOL OR CHEMICAL DEPENDENCY; ALSO DIAGNOSIS, TESTING FOR AND/OR TREATMENT WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HIV INFECTION, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR ACQUIRED IMMUNODEFICIENCY SYNDROME RELATED COMPLEX (ARC).

There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by “HIPAA” Federal Health Insurance Portability and Accountability Act. However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

I UNDERSTAND that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance upon my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to the facility releasing this information. If not revoked, this authorization is valid no longer than that reasonably necessary to effectuate the purpose for which it is given or until it expires 1 year from the date signed below or the conclusion of the litigation currently pending. I understand my signature below indicates I have read all information. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs authorization. **I HEREBY RELEASE any and all providers, THEIR EMPLOYEES, STAFF, AND AGENTS FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE DISCLOSURE OF THE INFORMATION SET FORTH ABOVE RELATING TO MY FILE.**

SPECIAL NOTE FOR MINORS: In Michigan, a minor has the authority to consent on his or her own behalf for alcohol or drug abuse treatment AND where he/she professes to be infected with VD or AIDS.

Every attempt will be made to have your form completed within 5 business days from the date below

Signature of Patient/Guardian: ______________________________ Date: ___________________

Office Use: ____ Date: ___________________