Spine Consultants, LLC
www.spineconsultants.org

Patient Request for Completion of Disability Form

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ State: ____ Zip: _____

Date of Request: _____ Phone: _____

I authorize this medical practice to release a copy of the specified protected health information as indicated below to (recipient):

Recipient Name: _____ Phone: _____ Fax: _____

Recipient Address: _____ City: _____ State: _____ Zip: _____

Purpose: medical provider to complete disability form

NOTE: Federal regulations require a description of how much and what kind of information is to be disclosed.

I authorize the use/release of the following PHI from (date) _____ to (date) _____.

☐ Complete the disability form using my entire medical record (all information) and send to the above named recipient.

☐ Complete the disability form using only the following medical record information and send to the above named recipient: _____

_____

NOTE: Initial the items to be excluded from the use/disclosure of protected health information:

_____ HIV/AIDS related information/records _____ Genetic testing information/records

_____Mental health information records _____ Drug/alcohol diagnosis/treatment or referral

I understand that if the recipient of the above information is not a healthcare provider or health entity covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these federal regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I may inspect or copy any information used/released under this authorization. I understand that I may revoke this authorization at any time, provided that I do so in writing, except in the instance that action has already been taken to respond to this authorization.

Unless revoked earlier, this authorization: ☐ is a 1-time request ☐ expires in 30 days ☐ expires in _____ days

The medical provider requires at least 7-10 business days to complete the disability form(s). No requests will be processed until this fee has been received. All disability forms will be mailed via US Post Office to the patient's address listed above upon completion unless indicated below:

☐ Call when completed for patient to pick up. Phone _____

☐ Please fax form to: _____ ATTN: _____ Fax #: _____

☐ Please mail form(s) to: _____

I understand there will be a charge for completion and agree to pay the $25.00 fee prior to the release of the completed form from the medical provider. I have read and understand the above information and agree to its content.

Name of person completing the form_____

Relationship to patient ☐ Self ☐ Other (specify)_____

Signature of person completing the form_____ Date _____