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DISABILITY / FMLA

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: _____

MAIL TO: Name/Company: _____
Street: _____
City, State, Zip: _____

CALL FOR PICK-UP: _____
(Name, Phone number)

Mail completed form back to Panorama Summit Orthopedics; Attn: Disability/FMLA; 265 Tanglewood Lane, Suite E-1, Silverthorne, CO 80498 or fax to: 970-262-7401.

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 Summit Orthopedics to release disability/FMLA information to the designated recipient.

_____ _____
Signature of Patient/Guardian Relationship to Patient

_____ _____
Today's Date Reason Patient Unable to Sign

PANORAMA
SUMMIT ORTHOPEDICS

970-262-7400
68 School Rd, Frisco, CO 80443
SummitOrthoPanorama.com