Advanced Podiatry
Request for Disability Form Completion

Patient Name: _____ Birth Date:_____/_____/_____

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

Home Phone:_____ Work Phone: _____ Treating Physician: _____

Last date worked or will work: _____ Return to work (or approximate) date: _____

Please indicate how you would like your completed form returned to you:

A. _____ Mailed to my home (the address above)
B. _____ Mailed to the insurance company authorized below
C. _____ I will pick the form up at doctor's office
D. _____ Please fax to this # _____

The $25 per form fee must be paid before the form will be completed.

PLEASE ALLOW 5 BUSINESS DAYS FOR THE COMPLETION OF YOUR DISABILITY FORM.

Authorization for Release of Information

I understand that I am under no obligation to sign this form and that the person(s) and/or organizations(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization

1. I Authorize the Following Health information to be Used and/or Disclosed.

_X_ Office Notes ____X-rays _____ Billing Records Other:_____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

Advanced Podiatry _____

3. I Authorize the Following Organizations to **Receive** and/or Use My Health Information. **(Include address)**

_____

_____

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

Payment of Disability Benefits

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact Advanced Podiatry at (636) 442-1541. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Discoluser of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that

__X___ No One _____Will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information. Amount or nature of remuneration: _____

8. Expiration of Authorization. This authroization will be effective until the following date or event:*Completion of care for podiatric injury*

_____ _____/___/_____ _____ Paid: Check Cash Charge

Patient Signature Date Staff Initial # _____