OAKLAND GENERAL SURGERY

AUTHORIZATION/DISABILITY/FAMILY MEDICAL LEAVE

Today's Date:____________

Patient's Name: ____

1. **Date of Surgery**: ____
2. **First Day Off Work**: ____
3. **Return to Work Date**: ____
4. **Doctor's name**:
5. **Do you want these forms**: Mailed to patient / Mailed to Company / Pick Up / Faxed
6. **Is this your first form filled out by our office?** Yes / No

Comments: ____

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*** Please allow 3-5 business days to process paperwork***

OAKLAND GENERAL SURGERY

Disability Forms

(Instructions for next page)

1. **This line is for the name of the company that we are releasing the disability forms to, i.e., "Unicare", "Aflac", "Sedgewick", "Ford", "Beaumont", etc.**

2. **The type of information we are releasing, i.e., "work and medical information".**

3. **An exact expiration date at least 90 days from the surgery date, i.e.,**

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize **Oakland General Surgery** to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits **Oakland General Surgery** to use or disclose to

1. ____ the following individually identifiable
Person or Entity to receive the information

health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc).

2. ____

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3. This authorization will expire on ____
Expiration Date or Defined Event

When my information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Oakland General Surgery has acted in reliance upon this authorization. My written revocation must be submitted to Oakland General Surgery, 1460 Walton Blvd Rochester Hills, MI 48309.

Signed by: _______________________________________ ________________________
Signature of Patient or Legal Guardian Relationship to Patient

_______________________________________ ________________________
Print Patient's Name Date

____
Witness