Huey & Weprin OB/Gyn, Inc
Authorization for Use or Disclosure of Protected Health Information

I _____, hereby authorize Huey & Weprin OB/Gyn, Inc to (check the following that apply):

☐ use the following protected health information, and/or
☐ disclose the following health information to whom: (etc. name of disability company or employer)_____

_____
_____
_____
_____

(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors, such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed for the reason of: (etc. disability insurance, FMLA)

_____
_____
_____
_____

(List specific purposes above.)

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires. (If no expiration date is specified this authorization will expire in 90 days)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Huey & Weprin OB/Gyn, Inc. I understand that a revocation is not effective to the extent that Huey & Weprin OB/Gyn, Inc has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Huey & Weprin OB/Gyn, Inc will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

OFF WORK REQUEST

PLEASE READ BEFORE SIGNING

This letter states you and your physician feel that starting your leave of absent from work is in your best interest. It is important for you to understand that your disability insurance company may not agree with this decision and therefore deny all or part of your disability payment. By signing this form you are giving us permission to release all requested medical information to:

_____.
(Name of your Disability and/or Employer Company)

You may revoke this authorization in writing at any time.

Effective October 1, 2004 a $25.00 fee will be applied for each disability form.

_____ _____
PATIENT SIGNATURE PRINT NAME DATE

_____ _____
DATE OF BIRTH PHONE NUMBER TO CONTACT YOU

_____ _____
PLACE OF EMPLOYMENT JOB DESCRIPTION

ARE THESE FORMS FOR YOU OR A FAMILY MEMBER?

FAMILY MEMBERS NAME AND RELEATIONSHIP

WHAT IS THE REASON YOU NEED TO BE OFF WORK?

WHAT IS/WAS YOUR FIRST DAY OFF WORK?

WHAT IS/WAS YOUR FIRST DAY BACK TO WORK?

WHERE WOULD YOU LIKE YOUR FORMS FAXED?

Company Name: _____
Attention: _____
Fax Number: _____

- OR -

WHERE WOULD YOU LIKE YOUR FORMS MAILED?

Name: _____
Address: _____
_____
Attention: _____

PLEASE ALLOW 7 TO 10 WORKING DAYS FOR FORM TO BE COMPLETED!

H & W Co.

H & W Co.