



• North Office •
20 West Wenger Rd
Englewood, OH 45322

937.771.5100 (ph)
937.832.3014 (fax)

• South Office •
3533 Southern Blvd. Ste 3100
Kettering, OH 45429

Release of Protected Healthcare Information to Employer, Disability Company or Other Third Party

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

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.

Patient Name & Date of Birth

Best Contact Number

Place of Employment

Job Title/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: _____

I, _____ understand this form will serve as my written consent allow Huey & Weprin, OB/Gyn to release necessary details of my healthcare information to the approved parties listed above, and further grant Huey & Weprin, OB/Gyn permission to return needed forms via the communication method I have indicated above.

Patient Signature _____ Date _____

**Effective October 1, 2004 a \$25.00 fee will be applied for each disability form.
Please allow our office 7-10 business days to ensure your forms are completed properly!
Thank you!**