# FMLA Protocol

**If you have a fracture, are scheduled to have surgery, and need FMLA, Short Term Disability, or Accident Insurance paperwork, the following will be needed:**

- The attached form completed **BY THE PATIENT**. We cannot accept this form if it is completed by anyone other than the patient, including spouse, child, caretaker, etc.
    - Exceptions: We can accept this form if filled out by the parent or guardian of a minor or the legal medical power of attorney of the patient.
- $20 processing fee per form needed
- All forms needed must be given to a Front Desk staff member at our clinic prior to or on the day of surgery. These can be delivered by a spouse, child, caretaker, etc, but must be completed by the patient themselves.

**Please allow up to 7 business days for our staff to complete the forms.**

Thank you!
The Orthopaedic Center
FMLA Email: tocfmla@toctulsa.com

# ☐ FMLA ☐ SHORT TERM DISABILITY

## AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

*phone*(918) 582-6800 | 1809 E 13th Street, Tulsa, OK 74104 | *fax*(918) 301-3102

**I. INDIVIDUAL INFORMATION** (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Patient Name: _____ DOB_____ Account #_____

Address:_____City:_____State:____ Zip: _____

Phone Number: (_____)_____-_____

**II. SCOPE & PURPOSE FOR SHARING INFORMATION - *Section II Parts A & B must be completed.***

I understand protected health information is information that identifies me. I hereby authorize **The Orthopaedic Center** to share my protected health information as set forth below. For reasons in addition to those already permitted by law.

### A. Person/Organization Receiving Information and Purpose for Sharing

1. _____ ☐ FMLA ☐ Short-Term Disability ☐ Other: _____
2. _____ ☐ FMLA ☐ Short-Term Disability ☐ Other: _____

☐ Pick-Up ☐ Mail to Patient ☐ Fax: (____)____-_____(include number if not stated on paperwork)

**This information cannot be sent via email.**

### B. Information to be Shared:

☐ Medical records pertaining to above claim

☐ Medical information compiled 12 months beginning on date initially seen: _____

☐ Other: _____

**I understand that by voluntarily signing this authorization:**

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- If I sign this Authorization to Use or Share Protected Health Information (PHI), I have the right to revoke this authorization at any time. The revocation must be made in writing to **The Orthopaedic Center** and will not affect information that has already been used or disclosed.
- I have a right to receive a copy of this Authorization to Use or Share Protected Health Information (PHI).
- I understand that signing this Authorization to Use or Share Protected Health Information (PHI) will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to: hepatitis, syphilis, gonorrhea, HIV or AIDS and/or may indicate that I am being or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this Authorization to Use or Share Protected Health Information (PHI) at any time by writing to **The Orthopaedic Center**.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the Authorization to Use or Share Protected Health Information (PHI) may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

**ONLY THE PATIENT WHOSE RECORDS ARE BEING REQUESTED OR A LEGAL GUARDIAN OF THAT PATIENT MAY SIGN THIS FORM.**

**Unless revoked or otherwise indicated, this Authorization to Use or Share Protected Health Information (PHI) will expire one year from the date of signature or upon occurrence of the following event: _____**

_____ _____

**Signature of Patient or Legal Representative** **Date**

_____ _____

**Description of Legal Representative's Authority** **Expiration Date (if longer than 1 year from the date of signature or no event is indicated)**

***==========Do not write below this line: For completion by The Orthopaedic Center only==========***

*Accepted by:* _____ *Date:* _____

*Information was provided to the individual on the following date:* _____