Northeast Surgical Group, P.C.

TO OUR PATIENTS regarding FMLA / DISABILITY FORMS:

It is imperative that you *READ* and *UNDERSTAND* the following protocol

>>>FMLA certification forms will be completed at no charge.

>>>FOR ALL OTHER DISABILITY, SICKNESS & ACCIDENT FORMS, LETTERS, ETC., please be advised of the **fees** for searching out, copying and providing Protected Health Information, per Michigan statute MCLA 333.26269

- **initial fee for request (**for a one-page form / letter**) DUE AT TIME OF REQUEST** **$20.00**
  - **$5 for each additional page of the form..** _____
  - $1.19 per page for the first 20 pages of any records…….. _____
  - 60 cents per page for pages 21 through 50… _____
  - 23 cents per page for pages 51 and over… _____

TOTAL _____

*****All outstanding fees must be paid prior to the release of information******

>>>The patient's signed authorization is required to release protected health information in order to complete any disability / FMLA form / disability letter. (our PHI Disclosure authorization specifically indicated for such = attached**) Health Care Information (your medical record) is CONFIDENTIAL and the release and distribution of any such information is restricted / protected per federal and state laws. The disability form, itself, may include an authorization for release of medical information; however, we have our own authorization form that must be completed (attached). This PHI disclosure authorization is valid only for the completion of the submitted form, and after such, the authorization expires. If your insurance carrier requests an additional form be completed or copies of any records subsequent to the completed form, you will be required to complete another PHI disclosure authorization form and responsible for any associated fees.**

>>>Any portion of the disability / FMLA form indicated for the patient must be completed prior to our portion being completed. **The patient, etc. is not to attempt to complete any portion of the disability / FMLA form *indicated for the attending physician*…the form will simply be returned to the patient as we cannot be responsible for someone else's documentation**.

>>>Disability forms are completed once the disability has commenced = once the surgery or hospitalization has taken place. The only instance when a disability form is completed prior to a surgery / admission is if the physician indicates such circumstances - - and the information provided may be insufficient to prove disability. >>>***FMLA forms may be completed prior to the surgery/admission; however, the information provided may be limited since we would be providing an estimated time away from work secondary to the scheduled surgery/admission.***

********** DISCUSS YOUR DISABILITY STATUS WITH YOUR PHYSICIAN SO IT IS ADDRESSED AND DOCUMENTED IN YOUR MEDICAL RECORD ACCORDINGLY.**

>>>Once the disability has commenced, ***we require a minimum of 7 working days to complete the form***, depending on the type and extent of information requested. (i.e. if a discharge date from the hospital is requested, the form would not be completed until the patient is discharged…*or we could proceed with completing it, but the patient may require a second form after discharge, thus incurring another charge.)*

>>>Patients must provide a phone number that we may call when the form is complete. Patients should plan on personally retrieving their form(s) from our office; however, if the patient has requested that another person retrieve their form(s), the patient must indicate who that person will be; POSITIVE IDENTIFICATION (photo I.D. = driver's license, state I.D., etc.) MUST BE PRESENTED WHEN THE FORM(S) ARE RETRIEVED.

>>>We are *not responsible for mailing disability forms* unless the patient provides a stamped, addressed envelope (no exceptions) - - in which case, we would retain a copy of that envelope as proof to where it was mailed. ***>>>We are not responsible for faxing disability forms - - this would be the patient's responsibility***.

>>>We do not provide protected health information, disability/FMLA updates, etc. via telephone or via fax. Your disability insurance carrier, employer, etc should NOT call or fax anything to our office - - they should, however, provide you (the patient) with a form requesting the necessary information, and we will proceed with complying as outlined above.

*****ALL QUESTIONS, ETC. MAY BE DIRECTED TO 586-228-0550 EXT #105**

Northeast Surgical Group, P.C.

Authorization for Use or Disclosure of Protected Health Information, as requested on DISABILITY FORMS & FMLA CERTIFICATION FORMS

*(This form must be filled out completely…**DO NOT LEAVE ANY BLANKS**)*

I, _____, _____ hereby authorize Northeast Surgical Group, P.C.
Patient's Name **Date of Birth**

to use or disclose the protected health information (PHI), as specifically requested:

- ❑ **ON THE DISABILITY CLAIM FORM THAT I HAVE SUBMITTED**
- ❑ **ON THE FMLA CERTIFICATION FORM THAT I HAVE SUBMITTED**
- ❑ **OTHER: _____**
- ❑ ***If applicable, explicitly state that the protected health information is pertaining to alcohol abuse, substance abuse, psychotherapy notes, psychiatric services, social services, HIV, AIDS, and/or ARC.)*_____**
- ❑ **REGARDING SURGERY / HOSPITALIZATION ON (DATE):_____**

The protected health information may be disclosed to:
NAME OF ENTITY (disability insurance company or employer)

_____

ADDRESS:_____

_____

This protected health information is being used or disclosed for the following purposes:
>>please check all that apply

- ❑ **to support my disability claim**
- ❑ **to support my FMLA certification**
- ❑ **"at the request of the patient"**

I understand that this authorization is specifically indicated and only valid for disclosure of protected health information, as indicated above, as requested on the form(s) I have submitted / letter I have requested, and a separate authorization (PHI disclosure) is necessary for any additional PHI requests. This authorization expires upon completion of the submitted / requested documents.

I understand that, as set forth in Northeast Surgical Group, P.C. Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Official at:

Northeast Surgical Group, P.C.
17375 Hall Road
Macomb Township, Michigan 48044

I understand that a revocation is not effective to the extent that Northeast Surgical Group, P.C. has relied on such authorization.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 Privacy Rule.

I understand that if I do not sign this authorization, then Northeast Surgical Group, P.C. will not release protected health information to the third party.

Northeast Surgical Group, P.C.

Authorization for Use or Disclosure of Protected Health Information, as requested on DISABILITY FORMS & FMLA CERTIFICATION FORMS *(continued…)*

*(This form must be filled out completely…**DO NOT LEAVE ANY BLANKS**)*

I understand that the release of my protected health information (which may include medical records and/or billing records) *by* Northeast Surgical Group, P.C. is only for the purpose of providing protected health information for disclosure to a third party: _____

Name of Entity that PHI will be disclosed to (Disability Insurance Co. and/or Employer (FMLA)

- ❑ *I, (the patient / patient representative) will retrieve my completed disability / FMLA form containing the medical information, as requested, from the office of Northeast Surgical Group, P.C..*
  Please contact me at the following phone number(s):
  _(_____)_____or _(_____)_____

- ❑ *I authorize the following person to retrieve my completed disability / FMLA form containing the medical information, as requested, from the office of Northeast Surgical Group, P.C.:*
  Name_____phone #_(_____)_____.
  (The designated recipient must provide proof of identity in order to retrieve the completed form)

Patient's complete / legal name: _____

Patient Date of Birth: _____ Social Security # XXX-XX-_____

Patient Address: _____City_____ State _____ Zip_____

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Signature of Witness (*REQUIRED – NOT OPTIONAL*) **Date**

FOR OFFICE USE ONLY

I am a Custodian of Protected Health Information (PHI) for *Northeast Surgical Group, P.C.*

- ❑ I have assisted _____D.O. in completing the referenced disability / FMLA / other letter form with the medical information as derived from the patient's medical record and provided by the physician.
- ❑ Along with completion of the referenced document, a total of _____ pages from the patient's medical record were copied and released, as described / requested on the submitted document.
- ❑ I have retained a copy of the completed submitted document and any released PHI for our records
- ❑ I have provided a copy of this authorization to the patient.

I declare that the above statements are true to the best of my knowledge.

_____ _____ _____
Printed name of Custodian of PHI Signature of Custodian of PHI Date

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- ❑ PATIENT retrieved the above referenced document/information.
- ❑ DESIGNATED RECIPIENT retrieved the above referenced document/information = positive identification confirmed via_____
- ❑ DOCUMENTS WERE MAILED IN ADDRESSED / STAMPED ENVELOPE PROVIDED WHICH WAS COPIED FOR REFERENCE

_____
Employee's printed name

_____ _____
Employee's signature Date