Texas Orthopedics,
Sports & Rehabilitation Associates

Office Use Only:
Acct#: _____
Doctor: _____
Date Received: _____

FMLA / Disability Release Form

I hereby authorize the use or disclosure of health information from the medical record of:

Patient Name: _____ Date of Birth: _____/_____/_____ Phone #: _____

Please fill in the following dates for completion of form:

Date of Scheduled Surgery: _____

Anticipated return to work date: _____

If Intermittent: ____ hours per day; ____ days per week, for ____ weeks

This information may be disclosed to and used by the following individual or organization:

☐ **Patient to pick-up**, call when ready

☐ **Fax to:**

Name: _____ Fax #:_____ Phone #: _____

☐ **Mail to address below:**

Name: _____ Phone #: _____

Address: _____

I authorize **TEXAS ORTHOPEDICS, SPORTS AND REHABILITATION ASSOCIATES** to release confidential health information about me, by completing a FMLA/Disability form, releasing a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed above.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes**, I consent to the release of this information.
☐ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I may revoke this authorization at any time by notifying Texas Orthopedics in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

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

_____
Relationship to Patient (If Legal Representative)