FMLA Protocol

If you are scheduled to have surgery or have a fracture and need FMLA, Short Term Disability, or Accident Insurance paperwork:

- The patient must complete the attached form. ***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.
- A $20 processing fee will be charged to the patient for each form TOC Staff completes on his/her behalf.
- **How to Request:**
    - To request for FMLA or Short Term Disability paperwork to be filled out by our staff, please email forms to tocfmla@toctulsa.com, fax to 918-925-3255, or hand them to the front desk staff at one of our clinics.
    - If you are having an elective surgery, do not wait until last minute to submit these forms, as they can take our staff about 14 business days to complete. We recommend submitting the forms you need for us to complete as soon as you are scheduled for surgery. These can be delivered by a spouse, child, caretaker, etc, but must be completed by the patient themselves.
- The Orthopaedic Center does not complete long term disability paperwork. That will need to be completed by your primary care physician.

Please allow at least 14 business days for our staff to complete the forms.

FMLA Email: tocfmla@toctulsa.com
FMLA Fax: (918) 925-3255

☐ FMLA ☐ SHORT TERM DISABILITY

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

phone(918) 582-6800 | 2431 E 61st Street, Suite 500, Tulsa, OK 74136 | *fax*(918) 925-3255

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

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. 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: (____)____-_____ (Fax number is required.)

This information cannot be sent via email.

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: _____