Medical Leave and Disability Form – Gynecology/Surgery

Important Information for Short Term Disability and FMLA for Gynecology/Surgery Patients

Your FMLA and/or Short Term Disability forms are due within 3-4 weeks prior to your surgery date. Forms are completed in date order received and can take up to 10 days for processing. While it may not always take this long, you will need to plan accordingly for form completion.

We are able to sign statements of disability and/or FMLA to begin the day of your surgery. The length of time you are disabled will be based on the type of surgery you have and according to our standard surgical guidelines. Additional out of work time beyond the recommended standard surgical guidelines is between you and your employer.

Those patients with medical problems will be handled on an individual basis. These exceptions will be based on medical necessity as determined by your provider.

The time you are disabled from work is a recommendation by your provider. Your Short Term Disability company may not always agree with the time your provider allows. If requested, we will provide medical documentation to support these recommendations. A signed release of health information authorization from you, must be on file prior to releasing any information. The signed authorization allows us to communicate, submit forms, medical records, etc to your short term disability company to validate/approve any recommended leave of absence. For your protection, we do not give out verbal information to employers or insurance companies.

1. Please indicate here if the physician has put you out of work for a medical reason: Yes ______ No ______

2. 1st day out of work or surgery date: __________________________ (Dates will be confirmed with your physician)

3. Please indicate how to route forms after they are completed: CHOOSE ONE - CIRCLE and COMPLETE BELOW
   a) Fax To: Name and Fax Number ________________________________________________________________
   b) Mail To: Name and Address ________________________________________________________________
   c) Pick up from our office. Name of person picking up forms _____________________________. Phone number to contact you or delegated person indicated above to pick up the forms when completed. ____________________________

The final decision regarding disability payment is made by your short term disability company.

Date ____________________________

Patient Name (Please Print) ____________________________________________

Patient Signature ______________________________________________________

Please complete and submit the following two forms (Medical Leave/Disability Form AND Permission to Release Health Information Form) with your employers required medical leave/disability form(s). Your physician must receive all forms within 3-4 weeks prior to your surgery date.

You will be contacted through MyCarolinas (Patient Portal) or by phone once forms are completed.
Instructions for Completing the Authorization for Release of Health Information

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization.

1. **Patient Information:**
   Please fill out all patient information that is listed (Name, Address, City, State, Zip Code, E-mail Address, and Telephone). You may give the last 4 digits of the patient’s social security number.

2. **Release Information From/Release Information To:**
   A. Assign what hospital, nursing home, doctors office or other healthcare center(s) will be releasing (copying and sending) the medical records.
   B. List the name, address, fax number and phone number of the organization or person to whom you want the records sent.

3. **Purpose:**
   A. Check the reason you are giving permission for the records to be released.

4. **Records to be released:**
   A. Please list the **dates of service** of the records you want released. (Dates the patient was in the hospital or nursing home or seen at the doctor’s office or clinic.)
   B. Please be specific as to what part of the medical record is being requested.
   C. Select the format you prefer to receive the information, paper or electronic.
   D. Select the method of delivery to receive records.

5. **Authorize:**
   Read the Patient Rights statements.

   Please print your name, sign, and date the form to confirm the release of the medical information requested. **Please note that a fee may be charged for copying the records.**
Patient Information: I give permission to release the health information of: (One Patient Per Form)

[Patient Information Fields]

Release Information From:
(List applicable Facility(s) and/or Practice(s))

Release Information To:
(Name of facility, person, company) (Relationship)
(Street Address or PO Box, City, State, Zip Code)

PURPOSE OF RELEASE (check reason):
☐ Request of individual/personal
☐ Continued patient care
☐ Legal purpose including discussions & proceedings
☐ Other

Fill in dates of treatment for records to be released:
Treatment dates: From _____________ To _____________

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary
☐ History and Physical
☐ Consultation reports
☐ Operative reports
☐ Laboratory reports
☐ Radiology/X-Ray Reports
☐ Pathology reports
☐ Entire Record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other

☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other

DELIVERY METHOD:
☐ Reg US Mail
☐ Pick-up
☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other

PATIENT’S RIGHTS – I understand that:
☐ I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
☐ This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.
☐ Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
☐ Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.
☐ CHS will not share or use my health information without my permission other than by ways listed in CHS’s Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.
☐ A fee may be charged for providing the protected health information.
☐ I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless another date or event is written here: ________________________

Signature: ________________________ Print Name: ________________________ Date: ________________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

Note the relationship/authority if signature is not that of the patient (Written Proof May Be Requested):
☐ Healthcare Agent/POA
☐ Guardian
☐ Executor/Administrator/Attorney in Fact
☐ Spouse
☐ Other:

☐ Parent
☐ Adult Child
☐ Affidavit Next of Kin

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor: ________________________ Print Name: ________________________ Date: ________________________

Authorization given to patient / Date of release: ________________________ via ☐ Mail ☐ Fax ☐ Other ☐ ID Verified ☐ DL/Other ID ________________________

CHS Employee Name & Title: ________________________ CHS Employee Signature: ________________________ Date: ________________________

Patient Information or Sticker

Name: ________________________
DOB: ________________________
Medical Record #: ________________________
Account #: ________________________