St. Charles Orthopaedic Surgery Associates, Inc.
Request for Disability Form Completion

Patient Name: _____ Birth Date:_____/_____/_____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Treating Physician: _____

Last date worked or will work: _____ Return to work (or approximate) date:_____

******COMPLETED DISABILITY FORMS CANNOT BE FAXED******

Please indicate how you would like your completed form returned to you:

The $20 per form fee must be paid before the form will be completed.

A. _____ Mailed to my home (the address above)
B. _____ Mailed to the insurance company authorized below
C. _____ I will pick the form up at the following location:
_____ St. Charles _____ Kisker Road _____ Winghaven / O'Fallon

PLEASE ALLOW 5 BUSINESS DAYS FOR THE COMPLETION OF YOUR DISABILITY FORM.

Authorization for Release of Information
(Complete this section if the form is being mailed to someone other that the patient)

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization

1. I Authorize the Following Health information to be Used and/or Disclosed.

_X_ Office Notes ____X-rays _____ Billing Records Other:_____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

St. Charles Orthopaedic Surgery Associates, Inc

3. I Authorize the Following Organizations to **Receive** and/or Use My Health Information. (**Include address)**

_____

_____

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

Payment of Disability Benefits

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact St. Charles Orthopaedic Surgery Associates, Inc. at (636) 946-7050. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that
__X___ No One _____Will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information. Amount or nature of remuneration: _____

8. Expiration of Authorization. This authorization will be effective until the following date or event: *_Completion of care for orthopedic injury*

_____ _____/___/____ _____ Paid: Check Cash Charge
Patient Signature Date Staff Initial # _____