WATSON CLINIC LLP

FMLA Forms Completion Request

Watson Clinic is pleased to assist you with completing of your FMLA forms.

Instructions:

- The patient/family member must complete their demographic information on the form.
- In order to comply with the HIPAA guidelines, the form must be accompanied by a signed HIPAA compliant authorization, Authorization to Disclose Protected Health Information (11 MESS MR 094), permitting Watson Clinic to release patient information.
  - ***If someone other than the patient is picking up the documents**, the patient must document the third party's contact information in the "Disclosure Information To" section of the authorization to obtain the records.*
  - *The patient must attach the Healthcare Surrogate or Power of Attorney with the form.*

Note: Processing time is 7 - 10 business days.

Effective April 1st 2019, there is a $25.00 forms completion charge.
Payment for forms completion is to be received prior to the processing of the form.

Payment method:

☐ Check – payable to Watson Clinic LLP

☐ Credit Card – please call 863-904-2628 to provide your credit card number. Someone will be available to take your call Monday through Friday 8:30 am to 5:00 pm.

Once forms have been completed, they will be routed to one delivery method selected:

☐ Pick up at the Main Clinic – 1 West Information Desk – 1600 Lakeland Hills Blvd.

☐ Fax to Employer: _____ Contact Person: _____

Phone: _____ Fax Number: _____

If you have any questions, please contact the Forms Completion Department at 863-904-2628.

Date:_____

Patient Name: _____

Phone: _____ **WC#**: _____ **DOB**: _____

Provider Name: _____

Approximate date condition commenced:_____

Leave is needed for: ☐ **Continuous** ☐ **Intermittent**

OFFICIAL USE ONLY

Date Payment Received_____ Payment Processed By:_____

WHITE - Medical Records YELLOW - Patient

RESET

Request will not be processed unless form is completed in its entirety.

WATSON CLINIC LLP
Quality Healthcare for Every Generation

Health Information Management • Release of Information Services
P.O. Box 95000 • Lakeland, Fl 33804-5000 • Telephone: 863-904-2652 • Fax: 863-904-2630

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PRINT

RELEASE MEDICAL RECORDS FROM:
Watson Clinic's Retention Policy is 10 years

Physicians/Specialty: _____

_____

_____

_____

_____

_____

DISCLOSE INFORMATION TO:

Name: _____

_____

Address: _____

_____

Phone: _____ Fax: _____

Physician Appointment Elsewhere: _____
(DATE and TIME)

IDENTIFYING INFORMATION:

_____ _____
PATIENT'S FULL NAME PATIENT'S DATE OF BIRTH

_____ _____
ADDRESS PATIENT'S PHONE NUMBER

_____ _____
CITY/STATE/ZIP PATIENT'S MEDICAL RECORD NUMBER

PURPOSE OF DISCLOSURE: *(select one of the following)* ☐ Patient's Request ☐ Other: _____
☐ Continued Care

Please check the following health information items to be released with a beginning date of _____ through _____.

☐ Office Visits ☐ Pathology Reports ☐ Lab Reports ☐ Immunizations **Radiology:** ☐ Reports ☐ Copy via CD

☐ Other: *(List specific information)* _____

DELIVERY INSTRUCTIONS: *(Select one of the following)*

☐ Mail to Patient ☐ Mail to Company ☐ Fax to Company ☐ Patient Pick-Up ☐ Electronic Delivery

I understand that I may be charged for copies of this information in accordance with applicable law.

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or treatment, treatment for substance abuse,birth control and family planning, communicable diseases, hospice, or genetic test results. By Signing below, I specifically authorize the release of this information.

I understand that this authorization will expire in **one year** from the date signed below unless otherwise specified _____.

I understand that once the information is disclosed, the information is subject to redisclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I may revoke this authorization by notifying, in writing, the Health Information Management Supervisor, Watson Clinic LLP, P.O. Box 95000, Lakeland, Florida 33804-5000.

I understand that Watson Clinic LLP will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form, Watson Clinic and its employees, officers, directors, medical staff members, and business associates are not responsible for the privacy and security of the above information once it is disclosed as allowed on the form.

X _____ _____ Date: _____
Signature of Patient or Patient's Representative Relationship *(if not patient)*

_____ _____
Name of Personal Representative Description of Authority to Act