sharecare | HEALTH DATA SERVICES

Dear Patient,

Virginia Urology has partnered with **Sharecare Health Data Services** to process all paperwork required to be submitted when applying for FMLA or Disability. Sharecare will be your point of contact for questions related to your FMLA or Disability leave. They can be reached at **1-866-273-4039.**

**When applying for FMLA or Disability leave:**

- You will need to complete this authorization form and return it with the blank forms to be completed for your employer.
- Please make sure you have *specific* instructions included as to where you are requesting the forms to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of Virginia Urology.
- You may elect to have completed forms mailed or faxed to the recipient listed.
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/Disability leave claim.** This means records may be attached to the forms that are being completed and will be released as indicated on the authorization.

**Return the completed Authorization for Release or Obtain of Medical Information form and blank FMLA/Disability forms to Virginia Urology.**

Fax: 804-521-1061 or

Mail: Virginia Urology
Attn: Medical Records
9101 Stony Point Dr
Richmond, VA 23235

**A fee of $30.00 per form is required prior to form completion.** For updates regarding the same qualifying condition/claim you will have 30 days for an update at no charge. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider. Once payment is received, your form will be completed and sent to the recipient listed on your release.

**For questions pertaining to FMLA or Disability leave paperwork, please contact Sharecare Health Data Services at 866-273-4039.**

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of Virginia Urology

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

*For FMLA/Disability/Other forms*

*The undersigned authorizes Virginia Urology to release my health information as noted below.*

***Phone 804-272-1438 | Fax 804-521-1061***

## *Patient Information *Please Print**

**Patient Full Name:** ________________________________________ **Other Names?** ________________ **SS#** (last 4 digits) _________

**Patient Address:** __________________________________________ **Phone #:** _________________ **Date of Birth:** ____________

**City:** ___________________ **State:** _______ **Zip:** _______ **Email:** __________________________________________

## *Doctor completing form*

**Doctor:** ________________________________________________________________________________

## Where do you want the form to be sent after completion?

**Name:** _____________________________________________ **Attention:** _______________________________________

**Address:** __________________________________________________ **Phone:** _____________________________________

**City:** _________________________ **State:** _________ **Zip:** ___________ **Fax** #: ___________________________________

## Information to be Released

___ Please complete the attached form for FMLA/disability leave. I authorize the release of supporting medical records to supplement my leave claim.

___ I am requesting leave starting: _____________________
(1st day of Leave)

___ I am requesting intermittent leave.
Reason: ________________________________________
Frequency: _______ times per __ week __ month

**<u>FMLA/Disability Forms Completion</u>**:
A fee *per form* is due <u>prior to completion</u> of the form(s). The fee schedule is as follows:
**$30 for initial form**, free updates for 30 days

You will be contacted by **Sharecare Health Data Services** with payment options after you return this paperwork to your Doctor.

## Authorization to Release Protected Health Information

**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.*** ____________ (*Please Initial)*

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _________________________. *If I do not specify expiration, this authorization will expire in 1 year.*

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

**Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

**Signature*:**_____________________________________________ **Date:** __________________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*