IOWA ORTHO
BONE • MUSCLE • JOINT • SPINE

Fax completed forms to:
515-362-7918 **-or- email to**
medrec@iowaortho.com

STD/FMLA Release of Information

ONLY complete and return this form if you require STD/FMLA paperwork to be completed for your employer.

We are pleased to assist you in completing your Disability and FMLA forms. Be advised there will be a 7-10 business day processing time frame, as well as a processing fee based on the type of form requiring completion.

We understand you may have an urgent deadline for your paperwork and will do our best to accommodate; however all paperwork will be processed in the order that we receive it without exception. I understand that the processing timeframe does not begin until all required pieces of documentation have been received by Iowa Ortho, this includes a signed release of information, the forms requiring completion and payment in full.

If you wish to retain a copy of the form for your records, you may do so by requesting a copy from our medical records department.

By law, we are required to have you provide us with a signed authorization giving your permission to disclose your information.

***Indicates Required Field**

***Patient's Name** *(First, Middle Initial, Last)* _____

***Date of Birth** _____ ***Preferred Daytime Phone Number** _____

OK to Leave a Detailed Phone Message? ☐ **Yes** ☐ **No** ***E-Mail Address** _____
**Email address will be used to provide status updates*

Form Type: ☐ **Disability form** ($20) ☐ **FMLA Form** ($20) ☐ **FMLA -and- Disability Forms** ($40)

Date of Injury: _____ **First Day Unable To Work**: _____

***Information of company or employer to receive forms:**

Name: _____ **Name:** _____

Address: _____ **Address:** _____

Phone: _____ **Phone:** _____

***Fax:** _____ ***Fax:** _____

NOTE: Must include fax number and address in order to be released

I authorize Iowa Orthopedic Center to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.

I acknowledge I am responsible to pay the required fee to initiate any processing of the forms and that the forms can take about 7-10 business days to be completed once all required paperwork and payments have been received.

Signature: _____ **Date:** _____