KCBJ

KANSAS CITY BONE & JOINT CLINIC

A DIVISION OF SIGNATURE MEDICAL GROUP OF K.C., PA

Short/long Term Disability/FMLA Release of Information Form

Do not complete if you are not employed or if you do not require Family Medical Leave.

Date:
Patient's Name:
Account Number:
Date of Birth:

Is this a Work Comp claim: Yes No

**** I authorize release of my protected health information for the purpose of completing form to:**

_____

Patient Signature: _____
Contact/ Phone Number: _____

Will be off after surgery (date): _____
Recommended Time Off After Surgery:
Total Joints: 8-12 weeks post surgery
Shoulders: 8-12 weeks post surgery
Arthroscopies: 2-4 weeks
Other:

_____ Call patient when completed (Patient will pick up)
_____ Mail to Patient
_____ E-Mail to Patient
_____ Fax to company:
Fax number: _____
_____ Paid

(For internal use only) Forms faxed in _____ Forms in chart _____ Forms hand carried _____

KCBJ Employee Initials _____

PLEASE NOTE: A minimum fee of $20.00 is required prior to completion of each form. Payment is expected at the time the form is dropped off and prior to sending to any authority. This must be hand carried or mailed to the office with check payable to Signature Medical Group.

Please allow 7-10 business days for form completion.
You are responsible for informing KCBJ when forms need to be updated.

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