PEDIATRIC &
ADOLESCENT
ASSOCIATES, P.S.C.

FMLA Forms
Authorization for Release

Effective January 1, 2005, Pediatric & Adolescent Associates, PSC will charge $10 to complete all Family Medical Leave Act (FMLA) forms. These forms require time and effort from our physicians and office staff to complete, so charging for completion of the forms is necessary.

This $10 charge is not covered by insurance and will be due from you when the form is picked up at our office. The forms must be picked up at our office; we will not mail or fax the forms. Your signature on this form is required.

Please allow 3-5 days for completion of FMLA forms.

Patient Name: ____________________________________

DOB: ____________________________________

Parent Name: ____________________________________

I acknowledge that I have received a FMLA form completed by PAA and authorize the release of any medical information related to my child in order to appropriately complete the requested form.

HIPAA Release Language:
I do not have to sign this authorization in order to receive treatment form Pediatric & Adolescent Associates. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at 3050 Harrodsburg Road, Lexington, KY 40503.

I understand that this authorization will expire within 30 days of date authorizing.

_________________________________ _______________________
Signature of Patient or Legal Guardian Date

Pediatric & Adolescent Associates, PSC
3050 Harrodsburg Road
Lexington, Kentucky 40503

FMLA Forms

If you are leaving FMLA forms for the physician to complete, you must give us the following information:

Parent Name: ______________________________
Patient Name: ______________________________
Patient DOB: ______________________________
Physician: ______________________________
Date(s) of visit(s): ______________________________

Illness / reason for FMLA forms:

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Forms needed by the following date: ____________________

If the physician has any questions related to the forms, the contact person is: ______________ Phone Number: ____________

____________________ ____________

Signature Date