

# WATSON CLINIC<sub>LLP</sub>

## 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.

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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 8:00 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.

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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: \_\_\_\_\_

**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	<b>RELEASE MEDICAL RECORDS FROM:</b> <i>Watson Clinic's Retention Policy is 10 years</i>	<b>DISCLOSE INFORMATION TO:</b>
	Physicians/Specialty: _____	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:**  Personal  Continued Care  Other: \_\_\_\_\_

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

**I understand that** I may be charged for copies of this information in accordance with Florida 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, or genetic test results.

**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. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

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

\_\_\_\_\_  
 Name of Personal Representative Description of Authority to Act