SHELL COSMETIC SURGERY CENTER
DAN H. SHELL III, M.D.
1068 CRESTHAVEN RD., SUITE 200
MEMPHIS, TN 38119
PHONE: 901-761-4844 FAX: 901-761-6929
EMAIL: A.PERRY@SCSC.HEALTH

FMLA/DISABILITY FORMS COMPLETION REQUEST

(Please Print and fill out form very carefully so that your forms are completed properly.)

DATE: _____

PATIENT NAME: _____ DOB: _____

PHONE #: _____

_____

1. **ARE FORMS FOR: ☐ PATIENT -OR- ☐ SPOUSE**
2. **REASON FOR FORMS: ☐ SURGERY/RECOVERY ☐ CARE FOR FAMILY MEMBER**
3. **COVID TEST DATE: _____** You will be required to quarantine following your test until your surgery date.
4. **SURGERY DATE: _____** Your return-to-work date will be determined by your physician.
5. **UPON COMPLETION, HOW WOULD YOU LIKE TO RECEIVE YOUR PAPERWORK: (CIRCLE ONE)**

PICK UP IN OFFICE FAXED TO EMPLOYER EMAILED TO YOU

If you have chosen mail, email, or fax, please provide the fax number or email address:

_____

Completion of disability or FMLA paperwork is $25.00 **PER SET** and payment is due when forms are dropped off **prior** to completion. You are responsible for the fee if your company faxes forms to the office on your behalf. Please note that the nurse has **5** business days after payment and forms are received for completion of all forms. Your signature below acknowledges this policy and gives our office permission to release information/medical records related to the FMLA/disability you are requesting completion of. Forms are sent **no sooner** than two weeks prior to your surgery. If you require an extension after surgery, it is **your responsibility** to notify our office prior to your return-to-work date.

SIGNATURE: _____DATE:_____

FOR OFFICE USE ONLY: # of forms: _____ Paid: _____ DATE: _____
CHART #: _____ INTIALS: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR MEDICAL CERTIFICATION IN COMPLETION OF FMLA AND/OR DISABILITY PAPERWORK

This form serves as consent to release medical information for the completion of FMLA and/or disability forms requiring a medical certification.

SECTION 1

PATIENT NAME: _____ DOB: _____

FAMILY MEMBER NAME (IF APPLICABLE): _____

EMPLOYER: _____

I, the undersigned individual, or a family member, have requested leave under the Family and Medical Leave Act (FMLA). The purpose of this disclosure is to determine whether the above listed individual qualifies for this leave under federal and/or state law.

SECTION 2

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I further understand that it is possible that the information described above may be re-disclosed by that recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations. This authorization is valid from the date listed below unless revoked with a signed, written notice to revoke my consent.

My signature below acknowledges that I have read, understand, and authorize the release of the information described above.

_____ _____

DATE SIGNATURE

_____

RELATIONSHIP TO PATIENT