Garey Orthopedic Medical Group
2776 N. Garey Ave, Pomona Ca 91767, 7777 Milliken Ave Ste 101 Rancho Cucamonga Ca 91730
Ph (909) 593-7437/ Fax (909) 593-0318

Request for Form Completion

Pre-Payment is REQUIRED

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member Name:_____

Patient Name:_____
(Last) (First) (Middle / Maiden)

Address:_____

_____ City:_____State:_____ Zip:_____

Date of Birth: ___ ___ / ___ ___ / ___ ___ Telephone #:_____

Cell/Work #: _____**Physician:_____**

Body Part:_____ Date Injury/Problem Began:_____ Last Day to Work:_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_____

Please check a reason: ___Continuous Leave ___Surgery and Post-Op Treatment ___Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work: FROM: _____TO:_____

Please allow 7-10 business days for completion of form AFTER PAYMENT RECEIVED.

I authorize Garey Orthopedic Medical Group to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization: _____
(I.e. Self / Family Member / Insurance / Employer)

Address: _____ City: _____

State: _____ Zip: _____ Telephone #:_____ Fax #: _____

Please check your preferred method of release:
__Mail the form to the patient's address
__Mail the form to the name/organization above
__Fax the form to number provided above I will pick-up the form. *A representative from our office will contact you to coordinate a designated date & time to pick up forms
__I will have someone pick-up the form for me: **Name** _____**Relationship**:_____

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying GOMG and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by GOMG before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. *This authorization will expire in 1 year or when I am released from my treating provider at Garey Orthopedic Medical Group.*

Signature: _____ Date: _____

Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other: _____

Please check form type: ___Disability $25.00___EDD Extension $15.00____All other form $20.00 initial $10.00 additional