Dear Patient,

Virginia Urology has partnered with **Sharecare Health Data Services** to process all paperwork required to be submitted when applying for FMLA or Disability. Sharecare will be your point of contact for questions related to your FMLA or Disability leave. They can be reached at **1-866-273-4039.**

When applying for FMLA or Disability leave:

- You will need to complete this authorization form and return it with the blank forms to be completed for your employer.
- Please make sure you have *specific* instructions included as to where you are requesting the forms to be sent after completion.
- Leave will only be certified based on your treatment plan while under the care of Virginia Urology.
- You may elect to have completed forms mailed or faxed to the recipient listed.
- **Please be aware that you are authorizing the release of protected health information to supplement your FMLA/Disability leave claim.** This means records may be attached to the forms that are being completed and will be released as indicated on the authorization.

Return the completed Authorization for Release or Obtain of Medical Information form and blank FMLA/Disability forms to Virginia Urology.

Fax: 804-521-1061 or

Mail: Virginia Urology
Attn: Medical Records
9101 Stony Point Dr
Richmond, VA 23235

A fee of $30.00 per form is required prior to form completion. For updates regarding the same qualifying condition/claim you will have 30 days for an update at no charge. You will be contacted by Sharecare Health Data Services with payment options after you return this paperwork to your provider. Once payment is received, your form will be completed and sent to the recipient listed on your release.

For questions pertaining to FMLA or Disability leave paperwork, please contact Sharecare Health Data Services at 866-273-4039.

Again, thank you for allowing us to serve you.

Sincerely,

Sharecare Health Data Services
Trusted Partner of Virginia Urology

sharecare

Date: __ __/__ __ /__ __ __ __

Request for Form Completion

Phone: 804-272-1438 | Fax: 804-521-1061

Pre- Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s).
The fee schedule is as follows:
$30 for initial form, for updates regarding the same qualifying condition/claim you will have 30 days for an update at no charge, plus any applicable sales tax.
You will be contacted by Sharecare with payment options after you return this paperwork.

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:_____

Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address(*Required)-:_____

Physician:_____

Date Injury/Problem Began:_____ **Last Day Worked:**_____

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:_____

I authorize Virginia Urology to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Fax #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address: _____

Please check your preferred method of release:
☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ **If I do not specify expiration this authorization will expire in 90 days.** If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(Please Initial)

Signature:_____ Date:_____
(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____)

Revised: 8/2021