

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

Return completed form in a sealed envelope, marked personal and confidential, to:

CENTRAL STATE UNIVERSITY
 HUMAN RESOURCES DEPARTMENT
 P.O. BOX 1004
 WILBERFORCE, OH 45384
 Phone: 937- 376- 6540
 Fax: 937- 376- 6245

EMPLOYEE/ PATIENT INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Employee's Name:	Social Security Number:
Employee's Address:	
City, State, and Zip:	Telephone Number:
Patient's Name:	
Patient's Age:	Relationship to Employee:

HIPAA-COMPLIANT AUTHORIZATION TO RELEASE INFORMATION:

By completing this document, I demonstrate my informed consent and authorization to allow the physician or practitioner identified on the back of this form to release and disclose to _____ - _____ such health care records and information concerning my current medical condition as is necessary to support my request for a leave of absence and/or any additional benefits the employer may provide. This authorization is made per my request. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of employer-provided benefits. I understand that my medical treatment is not conditioned upon me providing this authorization. I understand that if this authorization is for the release of psychotherapy notes I will complete a separate authorization for any other health information. I understand that information disclosed by the physician or practitioner to the employer may be subject to redisclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Employee Signature:	Date:
Alternatively, signature of Personal Representative and statement of authority to act on behalf of individual:	Date:
IF PATIENT IS ADULT FAMILY MEMBER OF EMPLOYEE:	Date:
Patient Signature:	Date:
IF PATIENT IS MINOR CHILD:	Date:
Signature of Parent or Guardian:	

EMPLOYEE'S STATEMENT REGARDING LEAVE TO CARE FOR A FAMILY MEMBER

When Family Leave is needed to care for a seriously-ill family member, you must explain the care you will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

Employee Signature: _____
Date: _____

STATEMENT OF PHYSICIAN OR PRACTITIONER

Medical Facts Regarding Patient's Condition:	
Date condition commenced:	Probable duration of condition:
Last day worked:	Date expected to return to work:
Is (or was) patient incapacitated (unable to work, attend school, or perform regular daily activities)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide dates of incapacity:	
If patient remains incapacitated, how long is incapacitation expected to last?	
If the patient's condition is of a chronic nature, please describe likely frequency and duration of periods of incapacity:	
Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.):	
By physician or practitioner:	
By another provider of health services:	

IF EMPLOYEE IS PATIENT, PLEASE COMPLETE THIS SECTION.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Did employee's condition arise out of employment?
<input type="checkbox"/>	<input type="checkbox"/>	Is/was inpatient care of the employee required? If yes, dates:
<input type="checkbox"/>	<input type="checkbox"/>	Is/was employee able to perform all of the functions of employee's regular position? (Answer after reviewing statement from employer of essential functions of employee's regular position, or, if none provided, after discussing with employee.) If no, dates:
<input type="checkbox"/>	<input type="checkbox"/>	If employee is currently unable to perform all of the functions of employee's regular position, is employee able to perform work of any kind? (If yes, please describe in comments section below, including the dates such restrictions are expected to last.)

IF EMPLOYEE'S FAMILY MEMBER IS PATIENT, PLEASE COMPLETE THIS SECTION.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Is/was inpatient care of the family member (patient) required? If yes, dates:
<input type="checkbox"/>	<input type="checkbox"/>	Did/will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? (If yes, please describe in the comments section below, including dates.)

PHYSICIAN OR PRACTITIONER INFORMATION

Comments:		
Physician Name:		
Address:		
City, State, Zip:		
Telephone:	Field of Specialty:	License No. :
Physician Signature:		Date:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT. IF YOU DO NOT RECEIVE A COPY, PLEASE ASK FOR IT.