Arizona Arthritis & Rheumatology Associates, P.C.

General Phone (480) 443-8400
Fax (480) 443-8697

FMLA Forms Completion Request

Arizona Arthritis & Rheumatology Associates 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 up to 15 business days.

Effective June 1st 2024, there is a $110.00 completion charge per form.
Payment for forms completion is to be received prior to the processing of the form.

Payment method:

☐ **Check – payable to AARA**

☐ **Credit Card – please call 480-443-8400 to provide your credit card number. Someone will be available to take your call Monday through Thursday 7:00 am to 6:00 pm.**

Once forms have been completed, they will be routed to one delivery method selected:

☐ **Pick up – Office:**

☐ **Fax to Employer:**_____**Contact Person:**_____

Phone:_____**Fax Number:**_____

If you have any questions, please contact us at 480-443-8400.

Date:_____**Patient Name:**_____

Phone:_____**WC#:**_____**Date of Birth:**_____

Provider Name:_____

Approx. date condition commenced:_____

Leave is needed for: ☐ **Continuous** ☐ **Intermittent**

FOR STAFF USE ONLY

Date Payment Received:_____**Payment Processed By:**_____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Release medical record from:
AARA's Retention Policy is 10 years

Physicians/Specialty:

Disclose information to:

Name:_____

Address:_____

_____

Phone:_____ **Fax:**_____

Physician Appointment Elsewhere:_____

IDENTIFYING INFORMATION	
PATIENT NAME	PATIENT DATE OF BIRTH
ADDRESS	PATIENT PHONE NUMBER
CITY/STATE/ZIP	PATIENT MEDICAL RECORD NUMBER

Purpose of disclosure (select one)**:**

☐ **Patient's Request** ☐ **Continued Care** ☐ **Other:**_____

Please check the following health information to be released with a beginning date of_____through_____

☐ Office Visits ☐ Pathology Reports ☐ Lab Reports ☐ Immunizations **Radiology:** ☐ Reports

☐ Other (list specific information):_____ ☐ Copy via CD

Delivery instructions (select one)**:**

☐ Mail to Patient ☐ Mail to Company ☐ Fax to Company ☐ Patient Pick-up ☐ Electronic Delivery

I understand that I may be charged for copies of this information in accordance with applicable 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,birth control and family planning, communicable diseases, hospice, or genetic test results. By Signing below, I specifically authorize the release of this information.

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, AARA, 4550 East Bell Road, Suite 170, Phoenix, AZ 85032.

I understand that AARA will not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization.

I understand the matters discussed on this form, AARA and its employees, officers, directors, medical staff members, and business associates are not responsible for the privacy and security of the above information once it is disclosed as allowed on the form.

Patient Signature or Represenative:_____

Relationship (if not patient)**:**_____ **Date:**_____

Name of Representative:_____

Description of Authority to Act:_____