PREMIER SURGICAL SPECIALISTS, PC

Michael J. Lucas, M.D., F.A.C.S.
Bruce B. McIntosh, M.D., F.A.C.S.
Mark A. Herman, M.D., F.A.C.S.
Nichole Urban, M.D.

WellPointe Medical Building
1701 South Blvd East, Suite 270, Rochester Hills, MI 48307 Phone 248-853-3100 / Fax 248-853-4300

AUTHORIZATION/DISABILITY/FAMILY MEDICAL LEAVE

Today's Date: _____

Patient's Name: _____

1. **Date of Surgery**: _____
2. **First Day Off Work**: _____
3. **Return to Work Date**: _____
4. **Doctor's name**: **Dr. McIntosh** **Dr. Lucas** **Dr. Herman** **Dr. Urban**
5. **Do you want these forms**: ***Mailed to patient / Mailed to Company / Picked Up / Faxed***
6. **Is this your first form filled out by our office?** **Yes / No**
7. **Phone number for Esis or UnaSource, if employer is automotive**: _____
8. **Any Comments?** _____

_____

_____

_____

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Disability Forms

(Instructions for next page)

1. **This line is for the name of the company that we are releasing the disability forms to, i.e., "Unicare", "Aflac", "Sedgewick", "Ford", "Beaumont", etc.**

2. **The type of information we are releasing, i.e., "work and medical information".**

3. **An exact expiration date at least 90 days from the surgery date, i.e., 01/01/2007.**

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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Premier Surgical Specialists, P.C. to use and/or disclose certain protection health information (PHI) about me to or for the party or parties listed below.

This authorization permits Premier Surgical Specialists, P.C. to use or disclose to

1. _____ the following individually identifiable
Person or Entity to receive the information

health information (specifically describe the information to be released, such as date(s) of

service, level of detail to be released, origin of information, etc).

2. _____

_____

_____

3. This authorization will expire on _____
Expiration Date or Defined Event

When my information is used to disclose pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Premier Surgical Specialists, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Premier Surgical Specialists, P.C. Privacy Officer at, 1701 South Blvd. East,
Suite 270, Rochester Hills, MI. 48307.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Witness