Carolinas HealthCare System

Medical Leave and Disability Form – Obstetrics

Important Information for Short Term Disability and FMLA for Obstetric Patients

Your FMLA and/or Short Term Disability forms are **due by your 34th week of pregnancy**. Forms are completed in date order received and can take up to 10 days for processing. While it may not always take this long, you will need to plan accordingly for form completion.

Since most pregnant workers present no medical, obstetrical or occupational reason to discontinue work, we will provide statements certifying the disability of pregnancy itself. **Specifically, we are able to sign statements of disability and/or FMLA to begin as of delivery and to end 6 weeks after a vaginal delivery or 8 weeks after a C-section delivery**. Additional out of work time beyond the recommended 6-8 weeks is between you and your employer.

Those patients with medical problems, which are adversely affected by pregnancy or adversely affect pregnancy itself will be handled on an individual basis. These exceptions will be based on medical necessity as determined by your provider.

The time you are disabled from work is a recommendation by your provider. Your Short Term Disability company may not always agree with the time your provider allows. If requested, we will provide medical documentation to support these recommendations. A signed release of health information authorization from you, must be on file prior to releasing any information. The signed authorization allows us to communicate, submit forms, medical records, etc to your short term disability company to validate/approve any recommended leave of absence. For your protection, we do not give out verbal information to employers or insurance companies.

1. Please indicate here if the physician has put you out of work for a medical reason: Yes _____ No_____
2. 1st day out of work or pregnancy due date: _____ (Dates will be confirmed with your physician)
3. Please indicate how to route forms after they are completed: **CHOOSE ONE - CIRCLE and COMPLETE BELOW**
   a) Fax To: Name and Fax Number _____
   b) Mail To: Name and Address_____
   c) Pick up from our office. Name of person picking up forms _____. Phone number to contact you or delegated person indicated above to pick up the forms when completed. _____

The final decision regarding disability payment is made by your short term disability company.

_____Date_____
Patient Name (Please Print)

Patient Signature _____

Please complete and submit the following two forms (Medical Leave/Disability Form AND Permission to Release Health Information Form) with your employers required medical leave/disability form(s). Your physician must receive all forms by your 34th week of pregnancy.

You will be contacted through MyCarolinas (Patient Portal) or by phone once forms are completed.

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Instructions for Completing the Authorization for Release of Health Information

Patients/Representatives need to carefully read and complete every section prior to signing and dating the form to ensure a valid and complete authorization.

1. **Patient Information:**
   Please fill out all patient information that is listed (Name, Address, City, State, Zip Code, E-mail Address, and Telephone). You may give the last 4 digits of the patient's social security number.

2. **Release Information From/Release Information To:**
   - **A.** Assign what hospital, nursing home, doctors office or other healthcare center(s) will be releasing (copying and sending) the medical records.
   - **B.** List the name, address, fax number and phone number of the organization or person to whom you want the records sent.

3. **Purpose:**
   - **A.** Check the reason you are giving permission for the records to be released.

4. **Records to be released:**
   - **A.** Please list the **dates of service** of the records you want released. (Dates the patient was in the hospital or nursing home or seen at the doctor's office or clinic.)
   - **B.** Please be specific as to what part of the medical record is being requested.
   - **C.** Select the format you prefer to receive the information, paper **or** electronic.
   - **D.** Select the method of delivery to receive records.

5. **Authorize:**
   Read the Patient Rights statements.

   Please print your name, sign, and date the form to confirm the release of the medical information requested. **Please note that a fee may be charged for copying the records.**

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

_____
(Name of facility, person, company) (Relationship)

_____
(Street Address or PO Box, City, State, Zip Code)

_____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☐Other_____

Fill in dates of treatment for records to be released:

Treatment dates: From _____ **To** _____

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.
Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other_____
☐ Operative Reports _____
☐ Laboratory reports _____
☐ Radiology/X-Ray Reports _____
☐ Pathology reports _____

☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☐ Physical Exam
☐ Laboratory Reports
☐ Radiology Reports
☐ Other_____
_____

☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other _____

☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other_____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May Be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:_____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release:_____via ☐Mail ☐Fax ☐Other_____☐**ID Verified** ☐**DL/Other ID**_____
CHS Employee Name & Title: _____**CHS Employee Signature:** _____**Date:**_____

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Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker

Name:
DOB:
Medical Record #:
Account #: