Jeffrey Thomas, M.D. ◆ James E. Splichal, M.D. ◆ Petros G. Nikolinakos, M.D.
Cynthia L. Shepherd, M.D. ◆ T. Jane Huang, M.D. ◆ Frederick Flynt, M.D.
Gustavo Westin, MD, M.P.H. ◆ Kuang S. "Aaron" Chang, M.D.

Form Information

Type of Form:	❍ Disability	❍ FMLA	❍ Insurance	❍ Other:

Please select your doctor below:

❑	Jeffrey A. Thomas, M.D.	❑	James E. Splichal, M.D	❑	Petros G. Nikolinakos, M.D.
❑	Cynthia L. Shepherd, M.D.	❑	T. Jane Huang, M.D.	❑	Frederick Flynt, M.D.
❑	Gustavo Westin, M.D., M.P.H.	❑	Kuang S. "Aaron" Chang, M.D.		

Fee Information:

First Form: $15.00 Each Additional: $5.00 per form Number of forms submitted:
Total Due: Payment Received By UCBC EMPLOYEE:

Payment Method	❍ CASH ❍ CHECK	❍ CREDIT CARD:			Exp:	CVV Code:
Type:	❍ VISA	❍ MasterCard	❍ Discover	❍ AMEX	❍ **Payment Not Received**	

What is your relationship to the patient? ❑ I am the **PATIENT** ❑ I am a **FAMILY MEMBER** – Name: ____________

Patient Name: ____
(Last) (First) (Middle/Maiden)

Address: ______________________ City/State/Zip Code: ______________

Social Security #: XXX-XX-________ Date of Birth: ____/____/______ Phone: ____________

Are you still working?	❑ YES	❑ NO	Last date worked:
Please check a reason:	❑ Continuous Leave	❑ Surgery/Post-Op Treatment	❑ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work: ____________

Please explain symptoms/limitations/difficulties currently preventing you from performing expected job duties:	**(For Caregivers Only)** Explain why you are requesting leave (transportation, caretaking, etc.)

I authorize UCBC to release the completed form(s) and/or the use and disclosure of my Protected Health Information to:

Name/Organization:		
Address:	**City/State:**	**Zip:**
Telephone:	**Fax:**	

Please check your preferred method of release:

❑ Mail the form to the patient's address	❑ Mail the form to the Name/Organization above				
❑ Fax the form to number provided above	❑ I will pick-up the form at UCBC				
❑ I will have someone pick-up the form for me	Name:				
	Relationship:	❍ Spouse	❍ Parent	❍ Child	❍ Other

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying UCBC and completing a revocation of personal representative form. However, if I choose to do so, I understand that my revocation will not affect any actions taken by UCBC before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand that the information in my medical record may include information relating to my treatment for mental health/psychotherapy, substance abuse and/or HIV/AIDS. This authorization will expire in 1 year unless specified: ____________

Signature:	Date:
Patient or Authorized Representative – Relationship:	

FOR UCBC OFFICE USE ONLY

DATE RCV'D BY RN				DATE COMPLETED				
UCBC MD	PN	JT	JS	CS	JH	FF	GW	KC