Garey Orthopedic Medical Group
255 E. Bonita Ave. Bldg. 1, Suite 101, Pomona Ca 91767
7777 Milliken Ave. Suite 101, Rancho Cucamonga Ca 91730
Ph (909) 593-7437 / Fax (909) 593-0318

Request for Form Completion

Pre-Payment is REQUIRED

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member Name:_______________________________

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

__________________ City:___________________State:_______________ Zip:__________________

Date of Birth: ___ ___ / ___ ___ / ___ ___ Telephone #:_____________________________________

Cell/Work #: ____________________________**Physician:____________________________________**

Body Part:__________________ Date Injury/Problem Began:________________ Last Day to Work:__________________________

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:__________________________

Please check a reason: ___Continuous Leave ___Surgery and Post-Op Treatment ___Intermittent Leave

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

Please allow 7-10 business days for completion of form AFTER PAYMENT RECEIVED.

I authorize Garey Orthopedic Medical Group to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization: ____
(I.e. Self / Family Member / Insurance / Employer)
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. *A representative from our office will contact you to coordinate a designated date & time to pick up forms
__I will have someone pick-up the form for me: **Name** __________________________**Relationship**:__________________________

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 redisclosed 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 GOMG 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 GOMG 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 or when I am released from my treating provider at Garey Orthopedic Medical Group.*

Signature: ______________________________________ Date: ___________________________

Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other: _________________________

Please check form type: ___Disability $25.00___EDD Extension $15.00____All other form $20.00 initial $10.00 additional