

**Preferred Women's Healthcare, L.L.C.**

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**MEMO**

To: All patients applying for disability

The new HIPAA privacy regulations require that you sign a particular authorization form in order for us to release information to employer and disability carrier so that you disability can be approved.

We will provide you a copy of the signed form for you records.

If there are instances where you want to restrict the release of certain diagnostic test results, please contact Cynthia Thompson or Preferred Women's Healthcare, LLC at 770-962-5100 to ask how to make changes to your authorization.

Thank you for your cooperation as these procedures are mandated by the HIPAA regulation to protect the privacy of your information.

# Disability Authorization Form

## Patient authorization for use and disclosure of protected health information

By signing this authorization, I authorize Preferred Women's Healthcare, LLC to use and/or disclose certain protected health information (PHI). This authorization permits Preferred Women's Healthcare, LLC to use and/or disclose the following individually identifiable health information about me (specially describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be release, origin of information, etc.): **All office and hospital notes pertaining to the disability including diagnostic test results.**

### The information will be used or disclosed for the following purpose:

For documentation and certification for disability. If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice will receive payment from the patient in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Preferred Women's Healthcare, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Preferred Women's Healthcare, LLC/500 Medical Center Blvd/Suite 290/Lawrenceville, GA 30046.

### I authorize Preferred Women's Healthcare, LLC to use and/or disclose certain protected health information (PHI) to the following:

\_\_\_\_\_ My employer \_\_\_\_\_  
(Name of Employer)

\_\_\_\_\_ My disability carrier \_\_\_\_\_  
(Name of Disability Carrier)

### This authorization will expire on:

\_\_\_\_\_  
(Expiration Date or Defined Event)

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Legal Guardian and Relationship to Patient

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

**Preferred Women's Healthcare, LLC**

500 Medical Center Blvd., Suite 290  
Lawrenceville, GA 30046

<input type="checkbox"/> <b>URGENT</b>  <input type="checkbox"/> <b>NON URGENT</b>
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Date Paid _____ Date Billed _____ Not Paid _____ How many forms _____
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**Disability/FMLA forms**

Date: \_\_\_\_\_

Account# \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Disability/FMLA form is for:

- Patient
- Spouse \_\_\_\_\_ (name)
- Other \_\_\_\_\_ (name)

Reason:

- Bedrest (preterm labor, high blood pressure, etc.)
- Pregnancy complications, delivery (please circle)
- Surgery
- Other \_\_\_\_\_ (reason)

First day out of work \_\_\_\_\_

Completed Disability/FMLA forms to be:

- Fax to: \_\_\_\_\_
- Fax to Insurance company
- Patient to pick up – Contact number \_\_\_\_\_

**Disability/FMLA forms can take 5 to 10 business days to be completed.**

**If there is an URGENCY with your Disability/FMLA form, please advise the Receptionist at this time.**

- \$25.00** Fee for each Disability/FMLA form. How many? \_\_\_\_\_
- \$10.00** Additional fee for each Disability/FMLA form that needs to be completed with in 72 hours. How many? \_\_\_\_\_

PWH Total Cost \$ \_\_\_\_\_  
Patient signature \_\_\_\_\_