DISABILITY, FMLA & Paid Family Leave QUESTIONNAIRE

Allow 7 Days for processing

An AUTHORIZATION FOR USE AND DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION must be attached

In order to process your claim; please **COMPLETE ALL** the information below.

Step1: Check all that apply:

☐ State Disability ☐ Private Disability ☐ FMLA ☐ Paid Family Leave (PFL)

Step 2:

- **Member/Patient must provide a Visit Verification of Treatment (VOT) from the treating physician for dates of disability. Claim may be delayed if VOT is not available.**
- **A new VOT is required for extensions and should have a new return to work date.**

Do you have a VOT from the treating Physician? ☐ Yes ☐ No

Patient Name: _____ Medical Record Number: _____

Phone Number: _____ SSN# _____

Name of Treating Physician: _____

What is the specific condition? _____

If Pregnancy:
Due date_____ Delivery date_____ Type: ☐ Normal ☐ C-Section

Step 3: State or Private Disability

First Date unable to Work: _____ Estimated or Actual Return to work date: _____

Step 4: Family Medical Leave Act (FMLA)

Do you agree for Kaiser to provide medical facts or specific condition information at the request of your employer? ☐ Yes ☐ No Initials_____

Is the FMLA to care for a Family member other than yourself? ☐ Yes ☐ No

If Yes, provide your name and relationship to the patient _____

Dates of FMLA: Starting:__/__/__ To: __/__/__

Is FMLA for a block of time? ☐ Yes ☐ No

If FMLA is for an ongoing CHRONIC CONDITION requiring INTERMITTENT TIME OFF:
How many episodes per month?_____ How many hours or days off per month?_____

Step 5: Paid Family Leave (PFL): For Care of a Family Member

How many hours per day is required to care for the Family Member?_____

Dates of Care: Start: __/__/__ End Date of Care: __/__/__

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Permanente Medical Groups

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Patient Name: _____
Kaiser #: _____ Date of Birth: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) _____
Email: _____

Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on providing or refusing to provide this authorization.

This authorizes the following Kaiser Permanente Medical Center(s): _____

To:
- ☐ Produce a copy of medical records specified below
- ☐ Complete form(s) (Please specify form type(s) in the PURPOSE section below)
- ☐ Allow named KP physician to view records

Kaiser Permanente may disclose this information to:
Recipient Name: _____
Address: _____
City: _____
State: _____ Zip Code: _____
Telephone Number: ( ) _____
Fax Number: ( ) _____
Email: _____

PURPOSE: The health information disclosed may only be used for the following purposes: _____

FOR COPIES, SPECIFY THE HEALTH INFORMATION NEEDED FOR USE OR DISCLOSURE

☐ Medical Office Records dated from _____ to _____
☐ Hospital Records dated from _____ to _____

NOTE: Hospital and medical office records may include information related to mental health, alcohol/drug, and HIV references. The actual treatment records from mental health and/or alcohol/drug departments, and/or results of HIV tests will not be disclosed unless specifically requested below.

SIGNATURE AND DATES REQUIRED IF ANY OF THE FOLLOWING BOXES ARE CHECKED

☐ Mental Health dated from _____ to _____ Signature: _____ Date: _____
☐ Alcohol/Drug dated from _____ to _____ Signature: _____ Date: _____
☐ HIV Test Results dated from _____ to _____ Signature: _____ Date: _____

☐ Specify Injury/Treatment: _____ Department: _____ dated from _____ to _____
☐ X-Ray: ☐ Images and/or Films ☐ Reports ☐ Describe: _____
☐ Laboratory Results dated from _____ to _____
☐ Other (specify): _____
☐ Protected Minor Records (Adolescent Confidential). Only applicable for patient requesters 12–17 years old.

Media Preference: ☐ Paper ☐ CD (if available electronically) **Delivery Preference:** ☐ Mail ☐ Pickup ☐ Fax ☐ Email

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

REDISCLOSURE: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date	Signature	If not patient, print your name and relationship