Sharecare Health Data Services

State Disability Release Form (EDD)

You or your insurance company has requested a disability form to be completed. Sharecare Health Data Services has been contracted by Corona Temecula Orthopaedics 341 Magnolia Avenue Suite 101 Corona, Ca 92879 to process your forms. **A processing fee of $30.00 for each new state disability form and $15.00 for each supplemental/extension form is required.** This payment is the responsibility of the patient and needs to be paid in full before completion of your form**.**

NO CASH PAYMENTS are accepted. Credit card, Check, or Money order only.

Please make checks/money order payable to Sharecare Health Data Services

ALL FORMS MUST BE RETURNED TO CORONA ORTHOPAEDIC'S OFFICE

Patient Information	
Patient Name:	DOB:
Address:	
Phone:	Email:
Doctor who is currently treating you:	
Where do you want the form to be sent to after completion? *PRINT LEGIBLY*	
Company name: **EDD**	
Receipt number:	
Disability information:	
Has the doctor released you back to work? ☐ Yes ☐ No	
Dates you were out of work: to	
Date released back to work:	
Work restrictions/comments:	

I authorize Corona-Temecula Orthopaedic Associates to release my Protected Health Information as indicated above. This authorization covers the release of medical records to supplement my disability claim. I understand that:

- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I can request a copy of this form after I sign and date it. ****EXPIRES 1 YEAR FROM DATE SIGNED****

Signature:	Date:

Any questions please call the Disability Desk at 951-735-6060

Please allow 7-10 business days for processing

Employment Development Department
State of California

Claim for Disability Insurance (DI) Benefits

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number										

Claimant Name (First)	(MI)	(Last)

I authorize

Corona-Temecula Orthopaedic Associates Medical Group, Inc.

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)	Date Signed (M M D D Y Y Y Y)

CREDIT CARD FORM

_____

Credit Card Payment

_____ ***I authorize Sharecare Health Data Services to charge my credit card for the amount stated below.***

(Please Initial)

_____ _____ _____ _____ (_____/_____) CRV__

Credit Card Number Expiration Date

Card Type (Circle one) VISA MASTERCARD AMEX OTHER:_____

$_____

Amount to Charge Account

X_____ _____

Signature of Cardholder

_____

Name on Credit Card (Please Print)

_____

Billing Address of Cardholder

_____

City, State, Zip Code

(Please do not write below this line, for Sharecare Health Data Services Use Only)

_____

Field Request ID