



SUPPLEMENTAL DISABILITY REPORT DISABILITY INCOME BENEFITS

P.O. BOX 617 • CONCORD, NH 03302-0617 • 800.852.3358 • FAX 603.226.2322 • WWW.NHLGC.ORG

SECTION I

Patient **MUST** Complete This Section and Sign Below.

1. PHYSICIAN'S NAME _____ PHONE (____) _____
2. NAME OF PATIENT _____
(Last) (First) (MI)
3. ADDRESS _____
(Street) (City/Town) (State) (Zip code)
4. DATE OF BIRTH ___/___/___ SOCIAL SECURITY # _____

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the medical care provider named above to disclose to New Hampshire Local Government Center (LGC) HealthTrust any information identified on this form and any other information relating to my current medical condition necessary to process my claim for disability income benefits. I acknowledge that this authorization is subject to the terms set forth in this paragraph and **on the reverse side of this form**, all of which I have read and understand.

PATIENT SIGNATURE _____ DATE _____

SECTION II

Physician **MUST** Complete This Section and Sign Below.

1. DIAGNOSIS & CODE _____
2. IF DISABILITY IS PREGNANCY RELATED: DATE OF BIRTH ___/___/___ TYPE OF DELIVERY: C Section Vaginal
3. DATE OF MOST RECENT TREATMENT _____
4. DESCRIBE CURRENT SYMPTOMS/TREATMENT _____
5. PATIENT HAS BEEN TOTALLY AND CONTINUOUSLY DISABLED (UNABLE TO WORK)
FROM ___/___/___ THROUGH ___/___/___
6. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK ___/___/___
7. DATE OF NEXT FOLLOW-UP APPOINTMENT ___/___/___

PHYSICIAN'S NAME (please print) _____ DATE _____

PHYSICIAN'S SIGNATURE _____ PHONE (____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RETURN WHITE COPY TO:

NH LOCAL GOVERNMENT CENTER
ATTN. STD PROGRAM
P.O. BOX 617
CONCORD, NH 03302-0617

PATIENT'S AUTHORIZATION (continued)

With respect to my authorization to release my medical information set forth on the reverse side of this form, I acknowledge and understand that:

- I can revoke this authorization at any time by giving my written revocation to my physician named on the reverse side of this form. Any revocation will not be effective as to disclosures already made and actions already taken in reliance on this authorization.
- My health care treatment by my physician will not be affected if I refuse to sign this form.
- I am authorizing disclosure of information protected under federal privacy law and that the information, once disclosed, could be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.
- If I do not revoke it, this authorization will expire 18 months from the date that I sign it.
- I am entitled to receive a signed copy of this authorization and a copy will serve as an original.
- I have read and understand this authorization and have signed the reverse side of this form.