

**DEPARTMENT OF ADMINISTRATIVE SERVICES
STATEMENT OF PSYCHIATRIC DISABILITY**

Patient's Name (Please Print)

Disability Claim Number

AUTHORIZATION: I hereby authorize any hospital or clinic, physician, nurse or practitioner, including my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee's Assistance Program (EAP), the Bureau of Workers' Compensation, the retirement system which I participate in or any other person, office or provider with knowledge of my illness, injury or condition to provide the Department of Administrative Services or its representative and state agencies involved with my return to work or claim for disability benefits with complete information as to my health and medical history, eligibility for Disability Retirement Benefits and any information required in connection with this claim, hereby waiving any and all privileged character of such information. I also hereby authorize the Department of Administrative Services or its representative to release any such information it receives to my health plan, the state's mental health vendor, United Behavioral Health (UBH), the Employee Assistance Program (EAP), the Bureau of Workers' Compensation the retirement system which I participate in and state agencies involved with my return to work or claim for disability benefits. I understand my health plan, the state's mental health vendor, United Behavioral Health (UBH), state agencies or other party acting as a representative for the state may contact me regarding their services in assisting me to return to work. A photocopy of this authorization shall be valid as the original. I understand that it is my responsibility under ADA to contact my employer if I wish to apply for reasonable accommodations under ADA or to obtain information about my rights under ADA.

(Signature) This authorization will be valid for 180 days from date of signature.

(Date)

NOTE TO TREATMENT PROVIDER: Please complete the following questions as thoroughly as possible. Failure to do so may result in a denial of your patient's benefits. Any cost for completion of this report is your patient's responsibility.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. DSM diagnostic code, with symptomology. _____

2. Please include interpretive results of MMPI or other psychological testing if done. _____

3. Provide dates of treatment. _____

4. List medications, changes in medications with dates changed, any side effects from medication, and lab results. _____

5. Describe patient's mood and affect. _____

6. Comment on patient's ability to carry out daily activities and follow instructions. _____

