FMLA / Disability Form Completion
Patient Authorization

Patient Name: ______________________________ DOB: ____________________________

Phone: _____________________________________

Address: ____

City: ________________________ State: _____________ Zip: ___________________

Email Address: ____

Completed Forms to be delivered to:

______ Patient (to address above)

______ Third Party: ____

Claim #: ______________________________ Fax #__________________________________

Address: ____

City: ________________________ State: _____________ Zip: ___________________

- **Anticipated Date to Leave Work: ________________________**
- **Anticipated Return to Work Date: _______________________**
- **Anticipated Due Date (If Related to Pregnancy): _________________**

I authorize __________________, to release medical information to insurance carriers regarding disability claims.

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.

Signature: ____ Date: ______________________

This authorization expires 180 days from the date of signature.

All forms are completed in the order that they are received.
A $25 fee per form is due prior to release of completed forms. Invoices will be delivered directly to the patient.
Should you have any questions, please call 972-895-2138.