MEDICAL INFORMATION RELEASE FORM

(FMLA and Short Term Disability, etc.)

- ***It is the patient's responsibility to return their completed paperwork to the appropriate company.***
- This form must be completed and returned to Women's Care with my FMLA/Disability Forms.
- It may take up to ***10 business days*** for all forms to be completed by Women's Care of Wisconsin.

In order for your request to be processed, the following information is required:

PATIENT NAME_____ **Date of Birth**_____

If for someone else, their name: _____ Date of Birth_____

Relationship to you:_____

Phone Number to contact you with questions:_____

PHYSICAN _____

Reason for requested time off:

- PREGNANCY Expected Date Of Delivery _____
  - Routine OB Appointments
- SURGERY or PROCEDURE Date Of Surgery _____

  Name of surgery _____

Have you already missed work? If so *what dates* and *why*? _____

_____

When do you anticipate your leave of absence to start? _____

Once your forms are completed, where would you like them sent?

- I will pick them up in (circle one) **Neenah** **Appleton**
- Please mail the forms to my home address on file at Women's Care of Wisconsin.

I understand that if the person(s) and/or the organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to WCOW. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Expiration date: This authorization is good until the following date(s) _____ or for 1 (one) year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that is accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____ ***DATE:*** _____

Reason for non-patient signature: _____

(If signed by other that the patient, state relationship and authority to sign for patient (i.e. parent of minor child, power of attorney for adult, etc.) revised 10/12