# FMLA & SHORT TERM DISABILITY - MEDICAL INFORMATION RELEASE FORM

________ It is the patient's responsibility to return their completed paperwork to the appropriate company.
(initial) Per our office policy, we are unable to fax your completed forms.

________ It will take 7-10 business days for all forms to be completed by Women's Care of Wisconsin.
(initial)

**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 ___________________________________

Physician name ______________________________________

**Reason for requested time off:**

- ❑ Pregnancy - Expected Date of Delivery _____/_____/__________ ❑ Routine OB Appointments
- ❑ Surgery or Procedure - Date of Procedure _____/_____/__________
- ❑ Intermittent Leave - Reason _______________________________________________________

**When do you anticipate your leave of absence to start?** Date _____/_____/__________

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

- ❑ I will pick them up (please check one location) ❑ 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 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 redisclosed 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. 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 one year from the date signed. I've had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient signature/legal representative __________________________________ Date _____/_____/________

Reason for non-patient signature _____________________________________________________________
(If signed by other than the patient, state relationship and authority to sign for patient (i.e. parent of minor child, power of attorney, etc.)