MediCopy Disability/FMLA Intake Form and Authorization

Where is the form/records coming from?

Facility/Doctor's Name:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the completed form/records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released?

Treating physician's name:

Time off is: (Circle one)

Intermittent or **Continuous**

Time off start date:

/ /

Estimated return to work date:

/ /

Additional information:

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Why are we sending the completed form/records?

Purpose of Disclosure _____

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: