Short/Long Term Disability/FMLA Release of Information Form

Do not complete if you are not employed or if you do not require Family Medical Leave

Date: ____
Patient's Name: ___________________________________
Account Number: __________________________________
Date of Birth: _____________________________________

Is this a work comp claim? (circle one) Yes No

****I authorize release of my protected health information for the purpose of completing form to:**

____

Patient Signature: ____
Contact/Phone Number: __________________________________

Will be off after surgery (date): _______________
Estimated return to work date: _______________

____Call patient when completed (Patient will pick up)
____Mail to patient
____Email to patient Email: _______________________________________
____Fax to company Fax number: __________________________________
____Paid

(For internal use only) Forms faxed _____ Forms in chart _____ Forms hand carried _____

KCBJ Employee initials: ______

PLEASE NOTE: A minimum fee of $25.00 is required prior to completion of each form. Payment is expected at the time the form is dropped off and prior to sending to any authority. This must be hand carried or mailed to the office with check payable to Signature Medical Group.

Please allow 7-10 business days for form completion. You are responsible for informing KCBJ when forms need to be updated.

MAIN OFFICE

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