DISABILITY/FMLA REQUEST FORM

Patient: Please make sure that you have filled out all "Patient Information" sections on the Disability/FMLA Forms that you are requesting we complete for you. The form(s) must also be signed authorizing us to release medical information on your behalf.
Please provide the following information to help us complete your form promptly and accurately.

Patient Name: ___________________________________ Date of Birth:_______________

Shoreline Physician:_______________________________ Today's Date: ______________

Person Requiring Form, If Other Than Patient:_____________________________________

Employer:_____________________________ Job Title/Description:____________________

Dates Off Work: From____________________________ Thru________________________

Who took you off from work?:____

Reason off work:____

Remarks or concerns:____

When forms are completed: (please check one)

_____ Call Patient Phone # _____________________________

_____ Mail Form Address ____

_____ Fax Form Fax #_____________________________Attn:____________________

Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

By signing this form, I am authorizing the release of my Protected Health Information as specified above or on the form(s) that we have been asked to complete on your behalf.

Patient Signature: ____

Charge of $15 for one form / $25 for 2+ forms / Same charge applies for any subsequent forms.
Payment must be made in advance. Forms will be completed within 5 business days from date received.

Office Use Only:
# of Forms Received ____________ Amt Paid ____________ Cash/Ck/CC Initials____________

Forms Completed: _____________ Mailed:________________ Faxed:____________________

Patient Pick Up: ______________ Initials:________________