# Form Completion Request

**Not answering every question on this form may delay us in getting your completed form to you. You must complete and sign the "AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION" at the bottom of this form for us to release your medical information.**

Patient Name:______________________________________ Today's Date: ______________________

Address:____________________________________________________________________________

Date of Birth: ___________________ Telephone number: ____________________________________

Your provider's name: (doctor, nurse practitioner or physician assistant) ___________________________

**Important question......Did you miss any work? ____yes ____no ____ not applicable**

- If so, what dates? ____________________________________________________________
- Reason missed work: __________________________________________________________

**Type of form:** (i.e. disability, FMLA, camp, day care, insurance, etc.) ______________________________________

**How would you like to receive your form?**

- ❑ Mail
- ❑ Call me when ready at this number: ____________________
- ❑ Fax to this number: ______________________________

**When do you need your form?** _________________________

- **Please allow 5 to 7 work days for form completion**

| For Office Use Only | |
|---|---|
| New for Work Cell | _____ |
| Work Cell Completed | _____ |
| Needs Provider Signature | _____ |
| Form Completed | _____ |
| Sent/ Faxed/ Mailed and filed | _____ |

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## AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

(Photocopy or facsimile of the original authorization will be considered as valid as the original)

**Information to be released from:**

**Information to be released to:**

______________________________________
Name of receiver

______________________________________
Address

______________________________________
City/State/Zip Code

**Information To Be Released:**
Information needed to fill out form(s)

**Need For The Disclosure:**
Form needs to be completed per patient request

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 the 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:

**Right to Inspect or Copy the Health Information to be used or disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information (medical records) department. **Right to Receive Copy of this Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form upon my request. **Right to refuse to sign this authorization -** I understand that I am under no obligation to sign this from and that the person(s) and or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization-** I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information (medical records) department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s)and or organization(s) listed above have already made in reference to this authorization.

**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 it accurately reflects my wishes.

SIGNATURE OF PATIENT/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 for adult, etc.)