RELEASE OF MEDICAL RECORDS

Patient Information

Name: _____

Address: _____

_____

DOB: _____

Authorization for Release

I, hereby authorize:

Name: **Caring Center For Women, PA** **Phone: 830-387-4790**

Address: **705 Generations Dr. Ste 101** **Fax: 512-396-7555**
New Braunfels, Texas 78130

To release, disclose, and deliver the medical information described below to:

Name: **FMLA and/or Disability Insurance Company**

Regarding my delivery/surgery

Purpose of Release:

Employment **Insurance**

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days.

The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the requested information to the extent indicated and authorized herein.

I specifically authorize the release of all medical information relating to the above named patient including but not limited to the following categories protected by the state of federal law: (1) Substance abuse (drug or alcohol) treatment (2) Mental health treatment and (3) HIV-AIDS related information, if such information is contained in the records. This request includes any report, correspondence, test results, and if any other information contained in the records, whether generated by the authorized provider or another entity.

The information is intended only for the use of the individual or entity name above. If you are not the intended recipient, you are hereby notified that disclosure or taking of action in reliance of the contents of this telecopied information is strictly prohibited. If you receive this telecopy in error, please notify us by phone immediately.

I understand that this authorization will automatically expire 120 days from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above, I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality.

I authorize the release of the information as indicated above

Signature: _____ Date Signed: _____

FMLA and Disability Forms – Patient Acknowledgement Form

WE ONLY ACCEPT ORIGINAL FORMS. WE DO NOT ACCEPT FORMS BY FAX.

WE WILL NOT ACCEPT FORMS FROM PATIENTS UNTIL ALL PATIENT AND/OR EMPLOYEE SECTIONS OF THE FORMS ARE COMPLETE AND THE APPROPRIATE MEDICAL RECORD RELEASE HAS BEEN SIGNED.

_____ **(Initial) IT MAY TAKE UP TO 14 BUSINESS DAYS TO COMPLETE FMLA AND/OR DISABILITY FORMS.**

_____ **(Initial)** THERE IS A **$25.00** FEE TO COMPLETE **EACH** SET OF FORMS, AND THE FORMS WILL NOT BE RELEASED UNTIL THIS FEE IS PAID. (*THERE IS A SEPARATE **$25.00** FEE FOR EACH SUBSEQUENT SET OF FORMS.)*

_____ ***(Initial) We do not fax completed paperwork. You will be notified by our office once your original forms have been completed and are ready for pick up.***

The Family and Medical Leave Act (FMLA) provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period to eligible, covered employees for the following reasons: 1) Birth and care of the eligible employee's child, placement for adoption or foster care of a child with the employee; 2) care of an immediate family member (spouse, child, parent) who has a serious health condition; or 3) care of the employee's own serous health condition. (Visit the US Department of Labor website for more information about FMLA).

_____ **(Initial)** ***FMLA forms may be completed after your due date is established or your surgery is scheduled.***

Disability insurance pays benefits to employees who are not working due to non-job-related accidents or illnesses. Many patients have disability insurance through their employers, or that they have purchased on their own.

_____ **(Initial)** ***Disability forms will not be completed until you are actually disabled due to birth of a child, surgery, illness or complication of pregnancy that requires the patient cease working.***

Please provide the information and dates below:

Reason for FMLA and/or Disability _____

Estimated Due Date _____ Delivery Date _____ Surgery Date _____

Dates missed work _____ Return to work date _____

Dates hospitalized _____ Hospital _____

I acknowledge that I have read and understand the above Caring Center for Women FMLA/Disability Form Policy.

Patient Name **(Printed)** _____ Date of birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Office use: (Initial and date) Fee(s) paid: FMLA forms _____ Disability forms _____