Authorization for Release of Medical Information
FMLA/DISABLITY FORMS

_____ _____
(Print patients full name) Date of Birth (Mo/Day/Yr)

_____ _____
(Street Address) Social Security Number

_____ _____
(City, State, Zip code) Daytime Phone

Do hereby authorize AHCFW

I understand that my health information may include general information related to my psychiatric health, Drug/alcohol abuse, communicable diseases, abortion, or other information I may consider sensitive.

Information Release To: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip code

Reason for Leave _____ Pregnancy _____Surgery _____Other _____

Request date for Leave _____ Return to Work date _____

Please circle which Provider: Daniel B. McMillan, M.D. Kelly E. Jensen, MD. Robert Thompson, MD
Molly M Gilham, M.D. Mary Kwiecinski, CNM Debbi Meslar-Little,CNM
Kari L. Somers, CNM April Reagan, CNM

Please check one*: ____FMLA ($20) _____Disability Forms ($20) _____ Other ($20)

Pt picking up form _____ Fax form to Attention: _____ Fax _____
(Date)

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification and that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would be protected by federal regulations. I need not sign this form to ensure healthcare treatment. Upon request, a copy of this authorization will be given to me.

_____ _____
Signature of individual or guardian Date

_____ _____
Signature of Witness Date

***Note:** **Fee must be paid prior to the completion of the forms.**
Please allow 10 business days for completion of forms.

OFFICE USE:
Fee of $_____ paid on _____ Initials _____
Provider has authorized _____ time off