HEALTHMARK GROUP

FMLA / Disability Form Completion
Patient Authorization

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Completed Forms to be delivered to:

_____ Patient (to address above)

_____ Third Party: _____

Claim #: _____ Fax #_____

Address: _____

City: _____ State: _____ Zip: _____

- Anticipated Date to Leave Work: _____
- Anticipated Return to Work Date: _____
- Anticipated Surgery/Due Date: _____

I authorize _____ to release medical information to insurance carriers regarding disability claims.

I understand that:

- My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I can request a copy of this form after I sign and date it.

Signature: _____ Date: _____

This authorization expires 180 days from the date of signature.

All forms are completed in the order that they are received.
A fee per form is due prior to release of completed forms. Invoices will be delivered directly to the patient. Should you have any questions, please call 972-895-2138.