

MediCopy Disability/FMLA Intake Form and Authorization

Where is the form/records coming from?

Facility Name: _____

Tell us about the patient.

Name: _____

DOB: _____

Email: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone#: _____

Where are we sending the completed form/records?

Name: _____

Email: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone#: _____

Fax#: _____

What would you like released?

Treating physician's name: _____

Time off is: (Circle one)

Intermittent or Continuous

Time off start date: _____

Estimated return to work date: _____

/ /

/ /

Additional information: _____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any

☐ AIDS/HIV/STDs, if any

☐ Psychological/Psychiatric conditions, if any

Why are we sending the completed form/records?

Purpose of Disclosure _____

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: _____

Date: _____

Relationship to patient: _____