Surgical Consultants of San Antonio

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR DISABILITY, FMLA OR OTHER BENEFITS

Patient Name: _____ DOB: _____/_____/_____

First day of leave (surgery date): _____/_____/_____

Estimated return to work date: _____/_____/_____

I hereby authorize and request Surgical Consultants of San Antonio to provide:

_____

Name of person &/ or disability company to whom form(s) need to be returned to:

At _____

Address or Fax and phone

Access to my medical information for the purpose of procuring disability, FMLA and/or similar benefits, and for that purpose only. This release authorizes:

- ✓ completion of form(s)
- ✓ telephone follow-up of information in forms, as needed
- ✓ photo copying medical records to support information in forms, as needed.

This consent will automatically expire in 90 days from the date signed below. Furthermore, this consent will be revoked upon compliance and will not serve any future request.

Signature of Patient/Guardian:_____Date:_____/_____/_____

Signature of Witness:_____ Date: _____/_____/_____

*****NOTE: Effective 10-01-2013: Dana L. Reiss, M.D. will charge $ 30.00 for the 1st set of FMLA / Short Term Disability forms. An additional fee of $10.00 will be applied for each additional form. The office requires 7 to 10 business days from the day we receive both the paperwork and full payment for the completion of disability and similar forms. There will be an additional $20.00 rush fee for paperwork needing to be completed before the above time frame or for same day processing. *****

Date Paid:_____/_____/_____ Received by: _____ Source: _____