WHS Fax: 920-749-4015

For Office Use

Form Completed _____

Form Sent _____

Form Scanned _____

Women's Health Specialists®

Form Completion Request

Not answering every question on this form may delay us in getting your form complete. You must complete and sign the "Authorization for Disclosure of Health Information" at the bottom of this form for us to release your medical information.

Please allow 7-10 business days for form completion

Patient Name:	Patient DOB:	Patient Phone:
Patient Address:	Patient Provider Name:	Patient Spouse Name:

FMLA REQUEST

Request is for you or your spouse? SELF ☐ SPOUSE ☐	Did you miss work? YES ☐ NO ☐ N/A ☐	If YES, 1st Day missed:	Planned Return to Work Date:
Reason for request: ☐ Surgery ☐ Pregnancy ☐ Delivery ☐ Post-Partum ☐ Other _____	**How would you like to receive your form?** ☐ Mail ☐ MyChart ☐ Call me when ready at this number: _____ ☐ Fax to this number: _____		When do you need your forms returned?
Intermittent vs Continuous Time (select one): ☐ Intermittent ☐ Continuous	**If Intermittent:** Episodes if incapacity is estimated to occur _____ times per ☐ day ☐ week ☐ month, and are most likely to last approximately _____ ☐ hour(s) ☐ day(s) per episode.		**If Continuous:** Amount of time Requested: _____

AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

(PHOTOCOPY OR FACSIMILE OF THE ORIGINAL AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL)

Information to be released from:
Women's Health Specialists
1818 N. Meade St. suite 330
Appleton, WI. 54911

Information to be released to:
_____
_____
_____

Information to be released: Information needed to fill out form(s) **Need for disclosure:** Form needs to be completed per patient request

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to inspect or copy the health information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information. **Right to receive copy of this authorization –** I understand I have a right to receive a copy of this authorization. **Right to refuse to sign this authorization –** I understand that I am under no obligation to sign this form and that the organization listed above who I am authorizing to disclose my information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to revoke this authorization –** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw this my authorization or to receive a copy of my withdrawal, I may contact medical records. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to the authorization. **Expiration Date:** This authorization is good until the following date: _____ or for one year from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATUR PATIENT/LEGAL REP: _____ **DATE:** _____

REASON FOR NON-PATIENT SIGNATURE: _____

(IF SIGNED BY OTHER THAN THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO SIGN FOR PATIENT SUCH AS POA/LEGAL GUARDIAN)