Form Completion Authorization

Where is the form coming from?

Facility/Doctor's Name: Invoice #:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email: Phone: Fax:

Address: City: State: Zip:

Who is receiving the completed form (recipient)?

Name: Company (if applicable)

Email: Phone: Fax:

Address: City: State: Zip:

What would you like released?

☐ In order for MediCopy to complete your FMLA and/or Short-Term/Long-Term Disability paperwork, information such as medical records and/or other forms of PHI is needed/requested from your employer/insurer. Examples of this may include diagnosis, treatment records, etc. **By checking this section, you (patient/patient representative) authorize MediCopy and its affiliates to release and disclose PHI limited only to the scope needed to complete your paperwork.**

☐ **Form & All Pertinent Records** ☐ **Form Only** ☐ **Other** ______________________________

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

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric Conditions, if any

Why are we sending the records?

Purpose of Disclosure: ____

How would you like the records sent?

☐ Email ☐ Fax

☐ I would also like a copy of the completed form.
Please send to FAX or EMAIL listed below:

____

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: