FMLA/SHORT TERM DISABILITY REQUEST
PATIENT TO COMPLETE ENTIRELY

Patient Name (please print)_____

Patient Date of Birth:_____

I am aware of **$20 fee per form** _____ (initials)
(physician will not complete unless fee has been paid)

My physician at this office is Dr. _____

Did you see any other physician for this condition prior to us: YES/NO (circle one)

What was the physicians name _____

What is or was your first day off from work (day of surgery unless otherwise stated by your physician in this office or you have been admitted to the hospital prior to surgery):
_____

List return to work day if known:_____

Please check <u>ONE</u> choice ONLY
Note: *We will either fax your form or you can pick the form up.
**** We will *only* call you to pick up your form.**

____ Fax completed form(s) to fax #_____

<u>OR</u>

____ I will pick up when completed: phone # _____

*****************OFFICE USE ONLY***************

Patient paid $20 fee per from YES

Consent/Release signed by patient YES

Printed Demographic sheet for billing YES

Patient Account number: _____

Tracking:

SHENANDOAH VALLEY SURGICAL ASSOCIATES

70 Medical Center Circle, Suite 213, Fishersville VA 22939 540-332-5999; fax: 540-332-5990

Authorization for Release of Medical Information

Print Patient Name _____ **Date of Birth (Mo/Day/Yr)** _____

Street Address _____ **Social Security Number** _____

City, State, Zip Code _____ **Home Phone** _____

I, _____ **, hereby authorize** Shenandoah Valley Surgical Associates **to release**
(Patients Name) (Name of facility)

DATES OF SERVICE: _____

(please check either entire record, electronic record, or other)

_____ **Entire Paper Copy of Record**

_____ **Entire Electronic Copy of Record**

_____ **Other (please specify)** _____

____ I do _____ I do not _____ N/A authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

PURPOSE OF DISCLOSURE: _____

Please provide current telephone number in the event we need to contact you: _____

Signature of individual or guardian or Personal Representative _____ **Date** _____

Signature of witness _____ **Date** _____

THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE IT WAS SIGNED